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SPECIAL ARTICLE

BLOOD AND TISSUE CHANGES IN ANAPHYLACTOID REACTIONS *

By P. J. HANZLIK, M. D.

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WE ALL RECOGNIZE THE GREAT IMPORTANCE OF SANITY IN PHARMACOLOGY AND, CONSEQUENTLY, IN A MAJOR PHASE OF THERAPEUTICS. THE WAVE OF THERAPEUTIC NIHILISM THAT HAS DONE AS MUCH HARM AS DID THE POLYPHARMACY WHICH STIMULATED THE VIOLENT SWING OF THE PENDULUM OF MEDICAL OPINION IS AT AN END. THERAPEUTICS, BASED UPON A SOUND PHARMACOLOGY AND TINCTURED WITH A WISE PERSONALITY, IS THE BACKGROUND OF OUR MODERN OPINIONS AND PRACTICES.

PROFESSOR HANZLIK, AS AN INVESTIGATOR AND TEACHER AND AS CONSULTANT TO THE IMPORTANT COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION, TELLS US AN IMPORTANT AND AUTHORITATIVE STORY OF ONE PHASE OF THIS SUBJECT IN THIS ARTICLE.

PROFESSOR HANZLIK ALSO WRITES A SCIENTIFIC EDITORIAL ON SOME PHARMACOLOGIC AND THERAPEUTIC SUBJECT IN EACH ISSUE OF CALIFORNIA AND WESTERN MEDICINE. I WANT TO MAKE PUBLIC ACKNOWLEDGMENT OF HIS SUSTAINED CO-OPERATION.

PROFESSOR HANZLIK, ALTHOUGH ALSO DOCTOR OF MEDICINE, DOES NOT PRACTICE MEDICINE. BUT HE IS ALWAYS DELIGHTED TO BE OF ASSISTANCE TO ANY PHYSICIAN ABOUT PROBLEMS IN HIS SPECIAL FIELD.—EDITOR.

ANAPHYLACTOID reactions which are elicitable by a variety of agents chemically and physically different, are accompanied by definite histological, physical, and chemical changes in the blood and tissues.

These consist of congestion, hemorrhages, embolism and thrombosis in certain viscera, chiefly in the lungs; peribronchial edema; perivascular edemas, occurring chiefly around the small vessels and capillaries. In the blood there are darkening, rapid sedimentation of corpuscles, frequently hemolysis, agglutination, and disintegration of corpuscles and agglutination and increased number of platelets, flocculation and aggregation of plasma, tendency toward acidity, diminution in carbon dioxide and alkali reserve, increase in ammonia and lactic acid after some agents; changes in blood volume, due to altered vascular permeability, blood dilution, etc. There are also changes in blood pressure, heart and respiratory rates and body temperature, ranging from moderate to severe, and often resulting in varying degrees of circulatory depression and collapse.

All of these changes put together indicate disturbances in important physical and chemical mechanisms of the blood and tissues, and are believed to be fundamentally responsible for widespread alterations in cellular activity, and hence for the symptoms and reactions.

The results indicate something of the nature and limitations of non-specific therapy and the dangers of intravenous medication.

THE highly cultivated field of allergy rarely suffers for lack of interest. In this respect, it is a keen competitor of the endocrine glands and vitamines. Without being desirous of just promoting an idea about allergy, I venture to present a brief summary of studies pertaining to one of its branches, namely, the anaphylactoid reactions. This will serve to illustrate what I believe is the trend of modern thought in this subject, a line of thought that is receiving wider application in the medical sciences. Certain unsuspected and practical deductions may be made from these studies, and they should, therefore, be of interest to physicians. Before discussing these, it will serve the purpose better and make the subject plainer, if a brief resumé of the development of our knowledge of anaphylaxis is first presented.

I. DEVELOPMENT OF ANAPHYLAXIS

This may be thought of in three general stages.

Recognition of the Phenomenon—In 1839, Magendie, the noted toxicologist and predecessor of Claude Bernard, reported that the first injection of egg-white was not toxic to rabbits, but that the animals would not tolerate the same dose several days later. In 1894, S. Flexner observed the same phenomena in rabbits treated with dog serum. The phenomenon of hypersensitivity to a poison was indicated, though not recognized as such, being regarded by some as a paradoxical reaction, in the tuberculin experiments of Koch in 1890; in studies with diphtheria toxin by von Behring in 1893; in the repeated toxic injections of serum in man of Arloing and Courmont in 1894; in the toxicity of eel serum for dogs of Hericourt and Richet in 1898; in the toxic injections of tuberculin effusions in guinea pigs of Courmont in 1900 and in the hypersensitivity reinjections of cocain of Adduco in 1894, though this latter work has never been confirmed. In his "L'Anaphylaxie" (1923), Richet tells us that it was the late Prince Albert of Monaco and G. Richard, who, in 1902, advised Richet and Portier

* Address before the Southern California Medical Association, November 14, 1924, Los Angeles.

to study the toxic properties of physalis. On returning to France, Richet was unable to procure sufficient physalis, and therefore decided to study the tentacles of actinia or sea-anemones, extracts of which were found to be very poisonous for dogs. Exceedingly small quantities were not toxic, but later injections of the same or smaller doses produced marked symptoms and death; in other words, a condition of hypersensitivity and the opposite of immunity. Richet coined the word "anaphylaxis" as against "prophylaxis," which he tried to, but could not, produce. Richet's studies stand out as recognizing for the first time the dependence of a hypersensitive state on a preceding injection of a protein substance and an incubation period of a number of days between injections in order that the sensitive state may develop. At this time, however, the fundamental importance of the phenomenon for biology was not yet appreciated. This came later.

Causal Factors and Hypotheses—Numerous authors extended the application of the principle of sensitization reaction to a variety of proteins and other agents; and advanced explanations based more or less on objective evidence, but unfortunately the evidence was too frequently confined to symptoms. The mechanism of the shock reaction was ascribed to some hypothetical substance as being specifically elaborated and fundamentally responsible. Among such substances were "apotoxin," "serotoxin," "sensibilisin," "anaphylatoxin," ferment action, disturbed ferment-antiferment balance, histamine, peptone, etc. It would not be profitable to discuss these, but it will suffice to state that not a single one of these substances has ever been demonstrated in, or isolated from, anaphylactic tissue. However, Bordet's famous experiment with "toxified agar," which was misinterpreted as a demonstration of the hypothetical "anaphylatoxin," led up gradually to a conception which is broader in scope than specificity and has nothing to do with hypothetical substances. This brings us to

The Anaphylactoid Reaction—This term is synonymous with idiosyncrasy, reaction, crisis, etc. By the anaphylactoid reaction is meant a symptomatic reaction to a substance without previous sensitization or injection, the symptoms and many other changes being practically indistinguishable from those of anaphylactic shock. Among various agents, chemically and physically unrelated, causing such reactions are agar, starch, arsphenamine, histamine, kaolin, serums, vaccines, peptone, organ extracts, metallic salts, etc. In patients, hypersusceptibility to antipyrin, iodoform, acetylsalicylic acid, orris root, and certain dyes is well known. Proteins are not necessary, and the best responses are obtained on intravenous injection, which is also true of anaphylactic shock. These reactions have been studied especially by Loewit, Milian, Stokes, Nolf, P. Schmidt, Abderhalden, Lumière, Kopaczewski, Widal, Novy, and others. Novy showed that injections of trypanosomes and dead bacilli give similar reactions. One of the most striking effects is seen with "toxified agar," first demonstrated by Bordet. (Bordet's experiment is carried out as follows: Four or five parts of serum of the same untreated, or another, guinea pig are incubated at 38 degrees C. with one part of 0.5 per cent melted agar for two hours. The mixture is then centrifugalized and this removes most of the agar, leaving a clear supernatant fluid which is removed and incubated at 38 degrees C. for fifteen minutes. Three to five cubic centimeters of this fluid are then injected intravenously into a 300 gm. guinea pig. In from three to five minutes marked symptoms, indistinguishable from those of anaphylactic shock, develop and death may occur. At autopsy, the lungs are found distended, congested and hemorrhagic, and histologically they show emboli and thrombi composed of agglutinated erythrocytes, platelets and fibrin.) Practically the same changes were found by Karsner and myself with forty odd different agents injected in several hundred guinea pigs, by De Eds in pigeons and by De Eds, Tainter and myself in dogs. Typical results will be illustrated presently.

In this connection it is interesting to note that V. Behring ascribed the cause of the symptoms of anaphylactic shock to platelet agglutination in cerebral vessels, liver, etc. Richet speaks of anaphylaxis in vitro, which really means the formation of precipitin, or the occurrence of precipitation when antibody (serum of sensitized animal) and antigen are mixed in vitro, and on injection the precipitate causes immediate and typical symptoms of shock. Changes in physical constants (viscosity, surface tension, refraction, hydrogen-ion concentration, coagulation) of serum in anaphylactic shock and after agar-serum have been demonstrated by Zunz of Brussels. What does all this suggest? According to Widal, there is a hemoclasia, or colloidoclasia; that is, a disruption of the blood elements, its colloids, etc., as the mechanism of both the anaphylactic and anaphylactoid reactions. In fact, many authors have come ultimately to some physical-chemical conception of the nature of these reactions, and there is more to be said for this than for the elaboration of toxins, or specific substances. We should look for something more tangible and definite than such hypothetical substances as have been proposed, and obtain, if possible, a clear demonstration of the objective changes. Therefore, before going further, I wish to invite your attention to some blood and tissue changes that have been demonstrated in different species.

II. BLOOD AND TISSUE CHANGES

Our object at first was to observe and describe fully the effects of a variety of agents which were alleged to cause reactions indistinguishable from those of anaphylactic shock. As stated previously, the reports of many observers dealt merely with symptoms. We took note of these and also made histologic sections of organs, determined whether there was muscular hyperexcitability, attempted analysis by means of pharmacological agents, tried preventive measures, and studied changes in vitro. It was found that the phenomena could be produced by a variety of agents unrelated physically and chemically and that suggested the nature of the mechanism. Finally we have made chemical analyses of blood and observations of physical changes in various ways. The work has been done on several different species, namely, on guinea pigs, dogs, cats, and pigeons. Enough has been done to give

a fairly good idea of the changes. A part of the work I am presenting here has not been previously published. A good part of the work has been done in collaboration with Professor Karsner of the Western Reserve University and during the past three years with Doctors De Eds and Tainter and other workers in the Stanford laboratory. (At this point a brief description of methods used was given and twenty lantern slides were demonstrated, illustrating the results with intravenous and intraperitoneal injections, perfusion experiments, excised organs, agglutination, prevention with epinephrine and atropine; chemical analysis of blood for hemoglobin, carbon dioxide and alkali reserve, hydrogen-ion concentration, lactic acid, ammonia, urea; changes in erythrocyte and platelet counts and conditions of pigeon's blood in vivo and in vitro; darkening, hemolysis and agglutination of dog's blood by a color photograph; blood pressure and respiratory changes, etc., after such agents as agar, arsphenamine, copper sulphate, histamine, peptone, chloroform plasma, hypertonic solutions, Tyrode solution, and in anaphylaxis.) Many of the details have been previously published; others will appear in papers soon to be published. Certain changes produced by arsphenamine, phosphate and hypertonic solutions have been confirmed by Jean Oliver, Denis and V. Meysenburg, and others. The recent studies of Dale and Kellaway show that, after injection of agar-treated serum, there is an increase in the number and agglutination of platelets followed by disappearance of them, the effects being explained by an action on the blood such as would occur from its sudden exposure to an extensive and mildly injurious foreign surface.

III. EXPLANATION OF, AND DEDUCTIONS FROM, THE RESULTS

The fundamental cause, or basis, of the anaphylactoid reactions is suggested from the emboli, thrombi, precipitates, agglutination or aggregation, and disintegration of erythrocytes, agglutination and increase in thrombocytes, hemolysis, etc. All of these changes indicate disturbances in cell surfaces. The alterations in chemical composition and in appearance of the blood (blood dilution, increase in hydrogen-ion concentration, reduced carbon dioxide, reduced hemoglobin, increase in lactic acid, and darkening, agglutination, increased sedimentation and hemolysis of blood, etc.) indicate disturbances in important physical and chemical mechanisms of the blood and tissues. The perivascular and peribronchial edemas indicate alterations in capillary and cellular permeability. As a result of all these changes there are alterations in equilibrium of ions, in differences of electrical potential, in surface tension, in osmotic pressure, in viscosity and in imbibition, and probably other changes in the cells. I have already stated that changes in physical constants have been demonstrated by Zunz in serum of animals shocked with agar serum. The net result of these changes is stimulation and depression, or, in other words, the mediation of functional changes in cells, recognized in part as symptoms, reactions, etc. There is nothing unexpected about this. In fact, such physical-chemical changes and alterations in cellular functions would be expected. This is due to the universal phenomenon of adsorption, resulting from the contact of substances with surfaces; in our case, of course, with surfaces of corpuscles, endothelium of blood vessels, plasma proteins and cells of the tissues. By adsorption is meant the well-known tendency of substances to accumulate at or on surfaces. As a result of this accumulation, energy is expended at the interface where the substance is in contact with the surface, and from this is derived a change in surface tension. Sometimes surface tension is defined as the tendency to the exposure of the smallest surface possible. The working of this force is nicely illustrated by the formation of rain water into droplets, oil into globules in an emulsion, the darting of a camphor granule on water, etc. Furthermore, it is well known that, by changing the surface tension, the contour or shape of objects can be altered. This is conveniently accomplished by the addition of salts, acids, etc., which increase the surface tension, and by bile, soap and most organic substances which lower it. In our case the change toward acidity and the disturbance in salt (ionic) balance would tend to operate in the same direction. By judicious selection of agents which lower and increase the surface tension it is possible to produce amoeboid motion in inanimate objects; for example, in oil droplets. In other words, contraction and relaxation, indicating changes in functional activity, and simulating stimulation and depression to a degree, can be produced by the intervention of physical forces alone.

Such phenomena illustrate the operation of and changes in only one kind of physical force. There are changes in many other forces, all probably going on at the same time. Hence, it is reasonable to expect changes in or modifications of cellular activity, the multiplicity of factors involved in the tissues being conducive, if anything, toward a complexity of symptoms and other changes. It has been suggested that the physical and chemical changes which have been described are the consequence, and not the cause, of anaphylactoid reactions. This is the view of Lumiére, who nevertheless regards the flocculations, aggregations and agglutinations as fundamental physical changes which bring about the physiological. It is obvious that agglutination, flocculation, precipitin formation, etc., are tantamount to saying surface changes, involving physical and chemical changes. Hence, it appears to me that the basis of the anaphylactoid reactions is a disturbance in the physical-chemical mechanisms of the blood and tissues.

Nature and Limitations of Non-specific Therapy —Many agents causing anaphylactoid reactions are used as non-specific agents in the treatment of disease, especially of that with indefinite or unknown etiology, the aim being to induce such reactions for the sake of producing beneficial therapeutic effects, if not cure. The effects appear to be brought about through widespread alterations in cellular activity. However, sometimes the reactions are alarming and even result in death. These changes would be expected from the embolism, thrombosis, agglutination and flocculation, which occur in the blood stream and in important organs. Hence, such agents should be used cautiously.

Dangers of Intravenous Medication—The same holds true with respect to the indiscriminate use of agents and drugs intravenously. From what has been said, it follows that physical and chemical changes in the blood and tissues may always be expected under these conditions. Dangerous results may occur with relatively inert and inactive agents; for example, with agar, acacia, starch and kaolin. In fact, the results cannot be predicted from the physical and chemical properties of the agents. Again, an agent may be beneficial to one function and detrimental to others. Intravenous therapy is chiefly a fad promoted largely by unscrupulous manufacturers, and, unforunately, also by some physicians who fail to realize the dangers involved, and to appreciate that most drugs so advocated are promptly and readily absorbed when given by mouth, hypodermically or intramuscularly. There is no excuse for administering distilled water, hexamethyleneamine, iodide and salicylate intravenously, because all of their ordinary effects are promptly and readily obtained when they are given by mouth. On the contrary, detrimental and undesirable effects may occur when they are administered intravenously. Recently, when a genito-urinary surgeon was asked to explain the urinary antiseptic superiority of hexamethyleneamine intravenously, which he advocated in preference to its oral administration, he replied by saying that he was told it was so. Unfortunately, hearsay evidence is not convincing. There are only two drugs for which, at present, the intravenous route is indicated to secure their therapeutic effects, and these are arsphenamine and strophanthine. But, even these two agents are being replaced by combinations with other drugs and by substitutes, in order that their effects may be secured intramuscularly and subcutaneously so as to avoid detrimental effects from intravenous injection. Such dyes as rose bengal, phenoltetrachlorphthalein and others, which are being exploited as diagnostic agents and injected intravenously, are not harmless. We have had considerable experience recently with these dyes in dogs, rabbits, guinea pigs, and pigeons. They cause hemolysis, impart a brown color to the plasma and even produce systemic symptoms, not to mention the local effects in veins (phlebitis). We have had no experience with mercurochrome, but scarcely a month passes without a call from a physician drawing our attention to the marked systemic reactions from this agent, and recent reports in the literature testify adequately to the occurrence of undesirable and harmful effects when it is used intravenously.

IV. CONCLUSIONS

1. Anaphylactoid reactions, which are elicitable by a variety of agents chemically and physically different, are accompanied by definite histological, physical and chemical changes in the blood and tissues.

2. These consist of congestion, hemorrhages, embolism and thrombosis in certain viscera, chiefly in the lungs; peribronchial edema; perivascular edemas, occurring chiefly around the small vessels and capillaries. In the blood there are darkening, rapid sedimentation of corpuscles, frequently hemolysis, agglutination, and disintegration of corpuscles and agglutination and increased number of platelets, flocculation and aggregation of plasma, tendency toward acidity, diminution in carbon dioxide and alkali reserve, increase in ammonia and lactic acid after some agents; changes in blood volume, due to altered vascular permeability, blood dilution, etc. There are also changes in blood pressure, heart and respiratory rates and body temperature, ranging from moderate to severe, and often resulting in varying degrees of circulatory depression and collapse.

3. All of these changes put together indicate disturbances in important physical and chemical mechanisms of the blood and tissues, and are believed to be fundamentally responsible for widespread alterations in cellular activity, and hence for the symptoms and reactions.

4. The results indicate something of the nature and limitations of non-specific therapy and the dangers of intravenous medication.

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REASONS FOR A CHILD GUIDANCE CLINIC

By ROBERT LEWIS RICHARDS, M. D., *San Francisco*

This neglected problem is truly a medical problem in its widest service, as well as scientific sense, but it is not a medical education problem as medical clinics basically are, and it has relationship to schools, courts, and social agencies, which are more than the accepted medical facts.

MEDICINE began in the dim past as a form of health service to man. Medicine remains in high esteem when she continues this function. People are not so much interested in medicine's scientific erudition as in what benefit medicine is to them individually. Research of itself is valued and praised when it is of medical service to people. We are presenting today not only a field of service where there is great opportunity for the growing formative stage of human behavior, but also among those in whom people are most interested, viz.—the young; the adolescent.

University clinic meetings are noted for their scientific interest and lack of positive conclusions along treatment lines. Practicing doctors' hospital meetings are noted for their stress upon diagnosis and the effect of treatment upon the individual. In child guidance clinics, we have not only the study of stages of mental as well as physical growth with all its trends and determining factors, but also the results in the individual child in its relation to the family, to the school, to the courts, and to the various social agencies. It is medicine in its broadest, most appreciated aspects.

Unsettled post-war families are finding themselves inadequate for the child problems of the present day. The schools estimate a cost of $4,000,000 for backgraded scholars in California for the biennium, in spite of physical examinations, dental examinations, and a school program far in excess of the supposedly essential needs of a few years ago. The juvenile courts are crowded, and the institutions for delinquents are admittedly inadequate. The worst crimes are committed by those under 24 years, and are increasing in numbers. The many organizations for those financially dependent have grown until we have organized community chests of large proportions, and even call for state and federal aid in addition.

More specifically, detailed surveys have been made of schools, courts, and dependants in six large cities, in several smaller cities, and in rural communities. There is striking unanimity in the findings. From back-graded, misfitted pupils in the grammar grades come later the juvenile delinquents, and later still the violent criminals or the chronically dependent. There are abundant evidences of at least partially remediable mental growth deformities. While physical defects, economic handicaps, lack of sympathy, and lack of sufficient intelligence are found, the paramount difficulty is found in the qualitative mental side, and has to do with the mental growth and behavior problems. The problem is twice as big as the mentally defective alone. Indeed the moron properly placed is a happy, effective member of the community. The problems remain after you have remedied all the physical ills and have increased all the weights, and given proper ventilation, light, and play to all the children. The teachers may be well paid and sympathetic, the judges without legal restraint, and abundant funds for all dependency organizations; and you still have your problem largely unsolved. All this is known from experience.

The mental hygiene value in preventing the socially disturbing psychoses and psychoneuroses is so evident that all organizations and institutions having to do with mental conditions are vitally interested in child guidance work. State hospitals alone cost California in round numbers about $10,000,000 per biennium, and that is a tax directly or indirectly of $1.50 per inhabitant per year. If you add to this the cost in schools, courts, and dependency organizations, you have doubled and trebled this amount. If to this financial loss you add the cost in family life and the loss in good citizenship, you have a staggering loss, demanding consideration and action by the California Medical Association.

Since the beginning of the problem of the best child development is, of course, the selection of the proper parents for the children, the lessons of a child guidance clinic will do more to secure this than any number of idealistic talks on eugenics. But the element of chance in heredity is not removed by Mendels' laws, and you cannot definitely foretell a child from a knowledge of the parents. You can learn its possible trends for good and bad; its probable strength and its probable weaknesses. Heredity is a vague chart of an unknown country, the undeveloped negative, the seed for planting—but results depend upon remembering the general landmarks, developing the negative properly, and growing the plant in the appropriate conditions. In the present day of individual indulgence and halting group action, we can expect only an academic interest in the principles of eugenics and child guidance work is more needed now than it may be later. Also I am heartily in sympathy with "self-expression" and "children's crusades" against arbitrary parental prohibitions, but guidance is necessary, and in practical experience, the child guidance clinic is most appreciated by the child itself. It was not established to support authority, but to see that children may have every chance to grow, to develop, to have their rights as far as their origin or heredity will permit, and also while they are not fixed, but formative. Child guidance searches the hereditary factors as no other effort does. It is not content with the history of disease incidence, but goes on to the behavior records, the personality trends, and the mental capacity and quality of the child's forebears.

Besides the data of origin of the child, there is the record of growth of the child, of epochal periods successfully or unsuccessfully passed, and why, of favorable and unfavorable conditions of growth and of the developing life pattern. There is a vast difference between the stage of purely sense perception and self-interest with jealousy and fears of the first years, and the dramatization of life in the next or pre-school stage, or stage of interest in the family as well as himself. The epoch of school with passing from the family protection to a wider, more impersonal, unsympathetic group is a stress too little recognized. It is not without reason that this has been called "the prickly stage," the "urchin stage," "the big injun stage," "the stage of pirates and robbers." The schools devote four years to this period, and serious school work begins in the fifth grade. It is a period of sorting, but unfortunately not a period of especially remedying defects, favoring growth in certain directions, establishing mental habits commensurate with individual possibilities. The tendency to regard all children as alike grows largely out of the adult transferring his own mental processes to all children, and not regarding the child as a growing different individual.

With the advent of puberty, a new element of growth enters, viz: an interest or relationship to another individual of the opposite sex. This looks to the establishment of a new family group and a repetition of the human cycle. The old family must pass and the new family be established. Mentally, this is the greatest transition of all, and is difficult or easy, depending less upon the hereditary trends than the previous environment favoring or opposing normal mental growth. Experience shows that few pass this stage without deformities and scars, which seriously interfere with subsequent life growth. The characteristic tendencies show earlier than 12 to 14 years, but are usually recognized then, because of the startling physical changes, which can be seen by anybody. It is a physical maturing, but a mental infancy. It requires mental guidance as much as infancy required physical guidance, but by both father and mother, because the bisexual is now to the front. Teachers deal with too large numbers of individuals: courts with only the socially delinquent; other organizations with dependent failures; some doctors with the established failures of growth or deformities; the Church is limited in its field—none of these can take the place of father and mother. It requires a patience unbounded, a supervision unremitting, and a confidence never obtainable by other than father and mother. It does, however, require the knowledge and co-operation in their respective fields of the schools, the courts, dependency organizations, doctors, and the Church. There is work for all, if we expect the success of group organization or democracy and mental health or fruition. It is not a single situation met and adjusted or failed in. It is a growing something that progresses, and is normal or stunted or deformed for the balance of life in a

social organization not now so much dependent upon leaders as upon co-operation of the units. It is the continuance of efforts that distinguishes this problem from the other problems of the various agencies mentioned, and leads to the conception of a child guidance. Medical clinics, courts, social agencies, etc., deal with concrete situations and adjust limited set problems. Child guidance service deals with a growth, a continued effort at mental hygiene favoring proper mental growths.

The factors of infectious diseases, malfunctioning organs, internal glands, or body chemistry, which are handled by physicians, may delay the rate of growth, but none of them attempt to determine the direction of growth, and others are only secondary factors in the problems of human behavior.

Neither does the school organization take into consideration the growth factors of the family environment or the emotional side of the child. Roughly, the school allows about four grades for growth differences, but is not equipped and cannot make the necessary search for the factors retarding mental growth. Waiting for four lost or back grades to show mentally retarded growth in the public schools is not economical or wise. We should not forget that investigations have shown that these back grades produce dependents and delinquents. Individually, it produces tragedy and despair in the pupil stamped as an inferior.

The courts and social agencies are fully occupied with the end-results. Primarily, they repress by punishment or aid temporarily by money. They are vitally interested in preventing such end-results, but their function is not treatment and prevention. A delinquent or a dependent with them is an individual for emergency management, but the treatment and prevention belongs to another co-ordinating organization. Frequently, in lunacy courts, I have, with the authority of the judge, outlined a plan of treatment promising success, but at that point we were blocked, and the continued application of the details of treatment was out of our reach. I have frequently been asked for advice by social agencies, and they have thereby acquired a better insight into the details of the problem, but they were limited in time and finances, and it was fully recognized that we were dealing with an emergency. In psychiatric medical clinics I have again performed the same functions in a diagnostic way, but the treatment end failed in continuance of application of details. The more recently established health centers have also practically been diagnostic and emergency treatment centers, but with no continuing treatment relationship. Psychopathic hospitals are valuable parts of this program, and perform a great purpose in their in-patient and out-patient services, but they cannot offer the continued effort or co-ordinate the efforts of agencies needed in the problems as a separate child guidance clinic can. The psychopathic hospital has also still the unmerited but real prejudice of mental disease to hamper it in any wider relationship at the present time.

This neglected problem is truly a medical problem in its widest service, as well as scientific sense, but it is not a medical education problem as medical clinics basically are, and it has relationship to schools, courts, and social agencies, which are more than the accepted medical facts. Child guidance service is by no means confined to the individual patient. The patient is studied from every known angle. Where there is an equipped medical unit to determine or treat any medical angle, the patient is sent there for that medical purpose, and no new machinery is installed. In the school management every existing school agency is given the data and advice as to how that particular phase can be managed, in view of all the known accumulated facts. The court is furnished in the same way with information and advice from the mental hygiene point of view and practical experience. The family, as the special nurturing soil in which the plant grows, is studied from all angles and aided in every way to place this child so that it can best grow as God intended. Every young child is overwhelmed with the authority and power of those about it. Every adolescent is overwhelmed by his own personality, which he understands only partly, guards jealously and mistrusts as we mistrust any untried machine. Either the young child or the adolescent responds quickly and fully to an intelligent approach in which he feels that he is understood. The medical clinics will give generously and largely in this plan, but they will receive in return in many ways. The expensive problem of the repeater and the one who does not co-operate in treatment will be further solved. The medical prejudice of the present day will be much broken down by the wider contact and practical service. The popular trial and error method of trying now this treatment out, and now that treatment, will disappear through the methods of such practical service as the child guidance clinic. Medicine will advance into a new field of preventive medicine comparable with asepsis, immunology, and various existing public health measures, not by a spectacular laboratory discovery, but by an extension into the field of mental hygiene. It will be a co-operative group including the family, the schools, the church, the courts, the social agencies, as well as medicine, and the group will stand together. At the same time this work will be under medical guidance and initiated by medicine. This is not socialized medicine, but medical leadership in the mental field which medicine has long neglected too much. Inasfar as medicine has always been social as well as scientific and altruistic, the child guidance clinic will also be social under medical guidance. What psychiatric problem can be solved in the clinic will be solved there, but no new machinery will be installed. Each existing agency will receive the same rewards it now receives, but there will be a co-ordinating center doing the psychiatric work not now done, and making preventive medicine operative in this stage of human life where success is most largely rewarded and failure is so woefully costly. There would seem to be no reason why a demonstration of these facts in Los Angeles and San Francisco should not be accepted and urged by the California Medical Association.

409 Fitzhugh Bldg.

Scientific infant-feeding and pseudo-scientific feeding are not synonymous; but some people make themselves believe so.—Nebraska Medical Journal.

LOS ANGELES' EXPERIENCE IN CHILD GUIDANCE WORK

By AARON J. ROSANOFF, M. D., *Los Angeles*

The aim of the child guidance clinic is preventive work along the lines of mental hygiene.

It is obviously difficult, if not impossible, to demonstrate fully the effectiveness of such work.

It has been estimated that during the first year of its work the child guidance clinic can handle about five hundred cases.

The clinic procedure contains nothing that is new in mental science, except perhaps as it involves a more complete organization for the carrying out of all that we know has to be done.

IN MAY, 1923, Miss Mildred C. Scoville, a representative of The National Committee for Mental Hygiene, came to Los Angeles in order to consult with persons in this city who are interested in mental hygiene, concerning the feasibility of introducing child guidance work here.

She brought information to the effect that the Commonwealth Fund had placed at the disposal of The National Committee for Mental Hygiene financial means for the purpose of organizing demonstration child guidance clinics in various cities in the United States. Twenty-five cities, besides Los Angeles, had already been negotiating for the purpose of securing such a demonstration clinic. All requests for such demonstrations could not be granted, and it was understood that only a small number of cities would be selected on the basis of possessing the most highly developed social agencies, which would work in co-operation with the demonstration clinic.

One of the requirements of The National Committee for Mental Hygiene was that local authorities undertake to organize and finance, to the extent of a minimum annual budget of $25,000, a permanent child guidance clinic to be maintained along the lines of the demonstration clinic. In the event of this city being chosen to receive the demonstration clinic, the latter would operate here for one year.

Great interest in this project was aroused in this community, and, when a few months later Dr. V. V. Anderson of The National Committee paid a visit to this city, in order to investigate the local situation and to proceed further with negotiations, a new organization was created, the name of which was Mental Hygiene Organization of Los Angeles County.

I need not enter here upon the discussion of the full scope of activities which this organization has planned. It was understood that during the first year of its existence it would concentrate its efforts almost exclusively on the problem of securing for this city a demonstration clinic, to be financed for one year by the Commonwealth Fund, and to be conducted under the auspices of The National Committee for Mental Hygiene.

The organization succeeded in attracting a number of prominent and influential persons in this community and securing quarters for the demonstration clinic in the Anita M. Baldwin Hospital for Babies, with the addition of an adjoining building and part of another building also adjoining, on the grounds of the California Lutheran Hospital. The local mental hygiene organization succeeded in securing not only funds for meeting its own expenses, but also pledges for funds necessary to maintain a permanent child guidance clinic, according to the requirements of The National Committee for Mental Hygiene.

The work of this organization resulted in Los Angeles being chosen from among twenty-six cities in the United States as the location for the demonstration clinic, which was then available. The clinic staff arrived, preliminary organization work was quickly accomplished, the quarters were prepared, and the new clinic was formally opened for the reception of patients on February 12, 1924.

The plans of the Commonwealth Fund involved the expenditure of between fifty and sixty thousand dollars during the year of demonstration. The demonstration clinic staff consists of a director, chief of staff, two psychologists, a chief of social service, six psychiatric social workers, a clinic manager, a statistician, and stenographers.

A local volunteer staff was then secured for work in connection with the child guidance clinic, the time given for such work by each member of the volunteer staff varying from one-half a day per week to full time. The volunteer staff consists of between thirty and forty members, including neuropsychiatrists, physicians and surgeons representing other medical specialties, psychologists, and social workers connected with various social agencies in the community, such as the Juvenile Court, Probation Department, Bureau of Catholic Charities, Federation of Jewish Welfare Organizations, the city schools, etc.

While the work of the demonstration clinic was to consist mainly of investigation and diagnosis, that of the local social agencies was to consist mainly in referring cases to the clinic and carrying out therapeutic recommendations resulting from the investigation and diagnosis.

The aim of the child guidance clinic is preventive work along the lines of mental hygiene. The theory is that such work is feasible; that is to say, that the prevention of mental disorders and of severe social maladjustment occurring on the basis of such mental disorders can best be prevented by taking cognizance of behavior abnormalities and evidences of beginning maladjustment in childhood.

It is obviously difficult, if not impossible, to demonstrate fully the effectiveness of such work. In a given case it may be judged, from the behavior and psychic abnormality presented by the child, that such child, if not taken in hand and properly treated, is threatened with development of grave, perhaps chronic and deteriorating, mental disorders; and it is not so difficult to show that measures of treatment in the given cases have been effective, insofar as they have removed the difficulties observed before the treatment was instituted. But it is never possible to say that, had the child been left without such attention, it might not have found a readjustment spontaneously and would surely have drifted toward the bad ending of which it was judged to be in danger. On the other hand, it can easily be shown that under conditions of the best possible management and mental hygiene measures the readjustment sought in some cases fails to materialize, and the bad

ending anticipated happens, in spite of all that is done.

The work of child guidance must and will be carried on by those who, in the absence of positive demonstration, have faith in the proposition that the problems of childhood maladjustment, and of all that it leads to later on, will not take care of themselves as well as they would be taken care of with the aid of careful and thorough investigation, diagnosis and treatment of each individual case.

It has been estimated that during the first year of its work the child guidance clinic can handle about five hundred cases. When one considers the amount of money and energy expended in order to take care of this number of cases, it will readily be thought that this work is expensive. It is true that during the demonstration year much of the work of the clinic is work of education, organization, developing a system of co-operation between the clinic and various social agencies, introducing mental hygiene functions in the operations of the social agencies themselves, and developing local machinery for the carrying out of a standard technic. It is probable that after the year's demonstration the child guidance clinic will be in a position to do its work more quickly and at lesser expense. Nevertheless, a careful selection of clinical material will always be in order.

The Child Guidance Clinic can never afford, for instance, the spending of much of its energy and time upon cases of marked mental deficiency, or upon other cases in which the problem obviously would be met only by permanent institutional custody. It is hoped merely that a too ready resort to institutional custody, which may prove detrimental rather than beneficial to a child, may be avoided in many selected cases.

In this connection it may be pointed out that social maladjustment in childhood, as well as in later life, arises on the basis of both constitutional and environmental causes. It is the opinion of many who have studied these problems that probably in no case are either the constitutional or environmental causes alone responsible for the maladjustment, but always a combination of the two. The most difficult task in any given case is to measure exactly the relative importance of each of these two groups of causes. Constitutional causes are probably not susceptible of much modification, and cases in which these causes may be judged to be of the greater relative importance are those which the clinic would not select for its most intensive work. The clinic proposes to select rather those cases in which the more modifiable environmental causes are of the greater relative importance.

It follows from what has been said that no cases can be rejected outright by the clinic. The clinic must and will undertake at least that amount of investigation of every case that is brought to it, which would suffice for a fairly reliable judgment, to the effect that the less modifiable constitutional factors are relatively of such great importance that further expenditure of time and energy on the part of the clinic would not be justified. In such a case the clinic would proceed to recommend the taking over of the case by an institution or such other social agency which may be properly charged with its further management.

The clinic procedure contains nothing that is new in mental science, except perhaps as it involves a more complete organization for the carrying out of all that we know has to be done. A child, upon being brought to the clinic becomes the object of the following steps of investigation and treatment: 1. Social investigation, which includes history-taking and home investigation, investigation of its school record, etc. 2. Physical examination. 3. Psychological examination, which includes measurements of intelligence, educational achievement, and of special abilities and disabilities. 4. Psychiatric examination. 5. Plan of treatment, which may include medical, psychiatric, educational or social measures, or any combination of these.

It would be impossible for an individual, however expert, to carry out such a procedure. Every phase of the work requires years of specialization, and for that reason becomes a problem for a group of workers, such as a child guidance clinic is made up of.

The data that are gathered by the various members of the group, in the study of the case, are brought together and discussed at staff conferences, which are held daily; and at these conferences further investigation or special diagnostic procedures may be suggested, such as x-ray, lumbar puncture, or any other measure, for the clearing up of doubtful points. At these conferences also the treatment is outlined and decided upon.

The problem then remains of following up the case for the study of its progress and modifying the treatment from time to time, according to indications as they may arise.

The Child Guidance Clinic has now been in operation in Los Angeles three months. In the meantime the local mental hygiene organization became the Southern California Society for Mental Hygiene, because some adjoining counties in Southern California became interested in the progress of mental hygiene, have expressed a desire to participate in the movement, and in some instances have gone so far as to take steps towards the organization of child guidance clinics in their own community.

The Mental Hygiene Society has taken upon itself to provide publicity not only through the daily press and by means of public lectures, but also through the medium of a monthly publication known as the Mental Hygiene Bulletin of the Southern California Society for Mental Hygiene.

This publicity has resulted in bringing not only a sufficient number of cases to the clinic to furnish work to full capacity, but has resulted in a waiting list of patients.

A few days ago the director of the clinic kindly furnished me with a statistical statement of the work of the clinic up to date. I learn that 252 applicants have appeared at the clinic. Of these, 106 were brought by parents, 79 referred by schools, 41 by physicians and other clinics, and 26 by various social agencies.

The clinic has not been in existence a sufficient length of time to afford instances by which the results of its work might be demonstrated. However,

the director has furnished me with abstracts of two cases which will be of interest as illustrating rather common types of difficulty.

The first case is that of a girl, 7 years 9 months of age, referred to the clinic by her grandmother because of unmanageable behavior at home and temper tantrums. The maternal grandmother had suffered from a nervous breakdown. A great-aunt had had a manic-depressive psychosis, and an aunt suffered from goiter and was nervous and irritable. At home she was constantly the witness of psychotic and hypochondriacal symptoms exhibited by various members of the family, and her brother teased her and frightened her frequently. The grandfather told her ghost and other fear-inspiring stories. The great-aunt who was suffering from a manic-depressive attack was seen by the child continually weeping and complaining of various physical symptoms and even observed by her in a suicidal attempt.

When she was a mere baby of fifteen months she began to have temper tantrums, during which she would hold her breath, turn purple, and grow quite limp. These were occasioned by trifles, such as the brother taking bread and butter away from her, and they were treated by dashing cold water over her and on one occasion by holding her under the faucet. She constantly complains of headaches, stomachache, and pain in the heart. These complaints are much like those of her great-aunt and grandmother. At night she frequently has nightmares. Her imitation of the symptoms which she had observed in the grown-up people in the house has gone so far as to lead her to make suicidal threats, and her nightmares were apparently repetitions of the ghost stories which she had been told.

The treatment consisted mainly of changing the family's methods with her. A plan was outlined for the family in specific detail, and her symptoms almost completely disappeared with surprising promptness. There can be no question that immediate and direct beneficial results have been secured in this case, in which symptoms had persisted from infancy. Would she have been destined to become definitely and permanently psychoneurotic if not thus cared for? Has she now been secured against such an outcome? It is in the nature of things that these questions cannot be positively answered, but if there is anything at all in mental hygiene it would seem that the results already accomplished are unquestionably worth while.

The second case is that of a boy, aged 13 years 4 months, who was referred to the clinic because he had never been able to learn to read well, in spite of the fact that he had been rated as of superior intelligence on the basis of a mental test given him at school. Investigation revealed that he had a mental age of 15 years 9 months; that is to say, 2 years 5 months above his chronological age, while his educational age was only 11 years. In reading and spelling he had about a nine-year rating, and it was clear that his special reading disability had stood in the way of his general educational progress.

He was compelled to repeat the low second grade twice and the low third grade once, whereupon he was for five semesters in an opportunity room. At the time he was brought to the clinic he was in an upper remedial adjustment room, but had not been making satisfactory progress there. Being intelligent and ambitious, he was keenly conscious of his difficulty and humiliated by his failures. This had apparently resulted in the development of an inferiority complex, which was heightened by an overcritical attitude on the part of his mother.

As is well known, such a disability as this boy has can be readily removed by special methods of training, which make use of motor processes. The removal of his reading disability by such a method will remove the only existing obstacle to his educational progress, and will take away all occasion for any inferiority complex. Such treatment has been recommended in his case and will, of course, take several months to carry out.

Those of us who have taken part in the mental hygiene movement in Southern California, and have had to do with the organization of the child guidance clinic here, feel encouraged with the work so far accomplished. We feel that this community cannot afford to get along without child guidance provision, and we propose to do all in our power to help establish such provision in Los Angeles on a permanent basis.

2007 Wilshire Boulevard.

How to Prepare and to Deliver a Paper to a Medical Society—In an interesting discussion of this subject, E. S. Moorhead (Canadian Medical Association Journal) emphasizes the obvious truth that: "No speech and no paper was ever spoiled by being too short, but many have suffered from prolixity. My ideal is to leave my audience with a lingering regret that I had not gone on a little longer. Prepare your papers, prepare as long a paper as you like, and then revise it. Revise it with a blue pencil, and with two mottoes before you: 'Brevity is the soul of wit,' and 'Precise knowledge puts an end to all conversation.' When you have got your paper to this stage, proceed to revise the English; see that your sentences run smoothly; if similar terms have to be used frequently, consult that most valuable aid, Roget's Thesaurus, in order that the same word may not be used time and again. You must then read your paper aloud. Do it at home. Read it until your delivery is fluent and punctuation correct. Note whether you come within the time limit or not; if you exceed the limit, cut again. Never apologize for your address, either at the beginning or at the end. To me there is nothing more offensive than to be told by the speaker that he had hurriedly prepared his paper a short while before. IF A GROUP OF INTELLIGENT AND EDUCATED MEN PAY YOU THE COMPLIMENT OF COMING TO LISTEN TO YOU, THE LEAST THAT YOU CAN DO IS TO OFFER THE VERY BEST CONSTRUCTED MATERIAL THAT IS AT YOUR COMMAND."

"The State Journal"—"The journal of a state medical association should be something more than a periodical that prints the proceedings of the state association and perhaps an occasional report of a county medical society meeting," says Albert E. Bulson Jr., editor Indiana Medical Journal (Bulletin A. M. A.). "It ought to be a live, up-to-date medical journal, with departments devoted to original articles of the best type obtainable, news and personal notes of interest to the medical men of the state, society proceedings, a monthly report from the Council on Pharmacy and Chemistry of the A. M. A., and should reflect the doings of medicine everywhere. The editorial department should be full of pep, and always in support of the highest ideals of personal and professional conduct on the part of medical men. The editor should not be afraid to speak in disparagement of duplicity or unethical conduct, or to offer constructive criticism of conditions that concern the practice of medicine."

ADULT DELINQUENCY

ITS PREVENTION BY MENTAL HYGIENE IN CHILDHOOD

By JOSEPH CATTON, M. D., *San Francisco*

The neuropsychiatrist finds that maladjustment expresses itself in tendency to suicide, unemployment, criminality, or some other form of failure.

We should not constantly spend money, time, and energy on attempting to improve those not capable of improvement.

It is the attempt of the individual to adjust himself in the wrong group or at the wrong level that brings disaster.

DISCUSSION *by Josephine A. Jackson, Pasadena, and Adelaide Brown, San Francisco.*

OTHER speakers are telling us, in some detail, of the technique of mental hygiene care, through child guidance clinics and children's habit clinics.

My communication is related to theirs, because mental hygiene in childhood may be a powerful weapon in the prevention of delinquency in the adult.

Society has failed largely in its handling of the criminal, the prostitute, the unemployed, and the pauper. The law has proven its failure with the criminal in a large proportion of the cases. Two-thirds to three-quarters of the inmates of state prisons are repeaters. The law has protected society temporarily by keeping the prisoner in custody: it has done some punishing. Reformation of the criminal has not succeeded at all in about 75 per cent of the cases, and we know little of the result in the other 25 per cent. How could the law have done otherwise? How could it reform, guide, or treat the criminal? First, it would have to know what sort of person it had to reform, to guide, to treat: and it has not had the machinery for obtaining this information.

Medicine may help in the problem, and here is the reason. Medicine will approach the criminal as she does the patient, and, through history and examinations, may determine physical and mental defects. Further, with special psychiatric, psychological, and sociological investigation, she will discover various maladjustments of the criminal and certain factors which appear to her to be in causal relation to the conduct disorder or crime.

The neuropsychiatrist finds that maladjustment expresses itself in tendency to suicide, unemployment, criminality, or some other form of failure. He feels that heredity taint, bad influences in infancy and childhood, poor home surroundings, lack of proper training, etc., etc., are etiological of maladjustment, and that certain forms of mental disease and defect may often be the basic causes.

One has only to glance at the literature on this subject to learn that careful surveys have been made of these relationships. There one may read of the percentages of insane, defective, and the rest, among the delinquents. But one should always ask for comparative statistics on groups of norms. In any event, one learns from Glueck that, among criminals at Sing Sing, 12 per cent are insane, 28 per cent defective, and 18 per cent psychopathic (58 per cent mentally abnormal); and from Anderson that, among the juvenile delinquents in Cincinnati, 26 per cent were psychopathic or mentally ill, 26 per cent subnormal, 8.4 per cent feeble-minded (66 per cent psychiatric problems); from Anderson that dependents in Cincinnati were 75 per cent psychiatric problems, 25 per cent being mentally ill; from Adler that 35 per cent of unemployed were "inadequates," and all the others showed paranoid make-ups, or emotional instability. Similar statistics are available for inmates in reformatories, for prostitute groups and others. Wherever surveys are made of these various delinquent types, from 50 to 70 per cent are found to present psychiatric problems.

The controls show no such high percentages of psychopathy. The mental defective averages do not show such a great difference between the adjusted and the maladjusted. In this regard, statistics of different observers show wide variations. Terman found about 22 per cent below average in the norm. In Anderson's school-children group, only 6.8 per cent were below average. A comparison of Anderson's totals on the school children on the one hand, with the totals of his delinquency group, and other delinquent groups on the other hand, is rather convincing. Only 6 to 10 per cent of his school children are problem cases and psychiatric cases, whereas 50 to 75 per cent of adult delinquents and failures are psychiatric cases. *In other words, in a group that, as a group, is getting along, less than one in ten present mental hygiene problems. In a group that in adult life is not getting along, two or three in each four are mental hygiene problems.* And medicine cannot apply to the adult what should have been applied to the child. Mental hygiene in childhood should have reached and should have helped in some degree, at least, two to three out of each four of our various adult delinquents.

Each of us has been able to trace through the childhood of "failure cases," the lack of proper habit-forming, proper guidance, proper education; pernicious home-life; and the rest. My small experience in examination of criminals in the San Francisco jails, would indicate that most of them were mental hygiene problems in childhood.

Hereditary factors have shown themselves repeatedly. Some mental defect has been found coupled with criminality in at least one in five of our cases. We have had the feeling that, had these defects been noted early and dealt with, the man might have found some adjustment at an appropriate level. These defectives might have made very good elevator boys, chore men, ranch hands, laborers, domestics, etc. They might have been more properly placed in industry and life; have been taught the satisfaction that comes with work well done, even though it is lowly; might have been prevented from developing "white-collar" aspirations with "overall" mentalities. Fernald prepared 50 per cent of his imbeciles so that after training they made good.

Without burdening you with repetition, may I state that our investigations have shown consistently the various factors which have been unearthed in more thorough and scientifically conducted surveys. At least 20 per cent of our cases show quantitative mental defect. At least 10 per cent might be diagnosed as medically insane. Another 20 per cent would be listed as psychopathic, and still another 20

per cent show marked psychoneurotic disturbance. I would say a grand total of 70 per cent show psychiatric aspects. One hundred per cent show behavior disturbance of antisocial or asocial type. But this sort of information has been available for some time. I believe the public is "sold" on that part of our problem. What the public wants now is to learn specifically our modes of treatment. The portion of the public which handles the purse-strings wants proof in the form of results. It wants to know from the *results,* and not from the *theory,* that our plans are economically sound, practical, and worth while.

I have been asked many times, in effect: Do you do more than investigate, diagnose, classify, recommend? What, concretely, have you done in the way of treatment? What are the positive evidences of results? Are the factors you find in examination of the maladjusted different from those in the adjusted?

I can answer the last question with a definite "Yes." I do not believe that the other questions can be answered so definitely at this time.

Mental hygienists have a big problem here: this problem of preparation for adjustment. It has taken nature thousands of years unnumbered to develop in man a nervous system, and harmones, and other factors beyond our knowledge. All this evolution has been towards the adjustment of each body cell to all of the others; and each of our body organs to the others. At its best, this adjustment lasts from three to five score years, at which point nature confesses its failure in death. We certainly, therefore, may approach this problem with all of humility and little of conceit. We have the right, however, to hope that something definite may be accomplished.

I believe that we ought to take stock. We ought to load our cause with every possible bit of optimism and enthusiasm. On the other hand, we ought to allow enough of common-sense pessimism to stay with us that we do not get the idea that we can buck evolution in its attempt to eliminate the unfit. We should not constantly spend money, time, and energy, on attempting to improve those not capable of improvement.

We have survey reports, statistical studies, diagnoses, and indicated recommendations. These point the way towards prevention of delinquency. We can get a clearer picture of how heredity, environment, and the personality-at-the-moment have determined certain capacities and limitations. We can contact the asocial and antisocial types early in life and prepare them for adjustment in some group and at the level where each belongs.

It is the attempt of the individual to adjust himself in the wrong group or at the wrong level that brings disaster. We must remember that it is not only the defective that needs help towards finding his level and adjusting himself to it. Many an adult delinquent gives clear evidence that during childhood he might have been detected and should have been dealt with as having an over or under-acting nervous system: as being of unstaple emotional make-up, maybe given to explosions, irritability, apathy, sensitiveness, or moodiness; as a neurotic, not unlike many of our adult types; as an incipient dementia precox, or paranoid type; as one with a disturbed sex psychology; as of asocial or anti-social tendency. All of these individuals would at least tend towards proper adjustment if the evolution of personality, and environmental factors were controlled in some degree.

209 Post Street.

DISCUSSION

JOSEPHINE A. JACKSON, M. D. (1955 Morton Avenue, Pasadena)—Dr. Catton's approach to this subject of dominant interest is both humane and sternly practical. That men of his type are bending their energies toward the solution of adult delinquency augurs well for the unfortunate individual and society as a whole. He tells us that maladjustment, which tends to crime, depends first on heredity, which, to me, is an insuperable argument for the sterilization of the unfit, beginning first with the criminal unfit and carrying it through all such members of society as are palpably incapable of transmitting a wholesome heredity.

This is not so much for the sake of society as for the sake of the wretched individual himself who must carry this inadequate equipment as a torturing ball and chain through all the days of his years.

Maladjustment results also from the lack of the right influences—psychic and material—in childhood.

Dr. Catton calls for intelligent control of the evolution of the child's personality. One means that presents itself therefor is to impress upon parents the significance of mental hygiene, which holds the total weight of weal or woe for the coming citizen.

Not dollars, nor erudition, but the faculty of adaptation is the child's supreme equipment. There should be a recognition by the masses and by all the wearers of white collars that more brains on the average top the overalls than top the white-collared mass. Manual dexterity means brains and assures adaptation.

ADELAIDE BROWN, M. D. (909 Hyde Street, San Francisco)—The increasing emphasis on habit-training in the hygiene of childhood must make a better poised adult life.

The fears of the dark, the need of a comfort to go to sleep with, of someone in the room, or of rocking to sleep—all these portend restless sleeping, an emphasis on the emotional and self-indulgent tendencies of the mind. The bad habit should not start, avoidance is easier than eradication.

Social adjustments can be taught early. Common courtesies of greeting, good-by, and thank you, mean self-control, appreciation of fellow-beings and social relations, and are thus far more than manners.

General physical and mental training, rather than specializing during adolescence, gives a control of brawn and brain on which body and mind may be developed later.

A social child, respecting his own and others rights, indicates mental guidance from birth. Of perfect specimens few grow, but many may be cultivated.

Ovarian Therapy—Emil Novak, Baltimore (Journal A. M. A.), emphasizes the fact that, rational as ovarian therapy appears to be in some conditions, the results are rarely striking and often nil to the level-headed observer. It cannot be assumed that a commercial extract can replace the normal ovarian secretion in the patient's body, or, for that matter, that it originally contains any of the active hormones of the ovary. Here lies the crux of the whole problem, whose solution will depend in large measure on the work of the biochemist. Until this day, the physician who uses ovarian therapy should keep his feet on the ground and not let himself be carried away by the exaggerated claims of those who have something to sell or the ill-advised and premature reports of honest but deluded professional colleagues who have not yet learned the dangers lurking in the "post hoc propter hoc" method of reasoning. As I once heard a wise man say, "Ought we to assume, if the administration of cascara relieves constipation, that the constipated individual had been a victim of hypocascarism?" There can be little question as to the future importance of ovarian therapy—as regards its present importance there is considerable room for discussion.

THE HABIT CLINIC FOR THE PRE-SCHOOL CHILD

By SYDNEY KINNEAR SMITH, M. D., *Oakland, Calif.*

There is, of course, no deep mysticism or any subtle psychiatric procedure employed, but only an attempt made to dispense common sense in small doses.

FROM what has been said by Dr. Richards and Dr. Anderson, one does not need to dwell further on the work of mental hygiene as touching childhood, its history, and recent manifestations in this country. Nor does one need to emphasize more fully to a group such as this the real need for such work. However, granting the need for juvenile mental hygiene advancement, we feel that in a symposium of this nature it is pertinent that we focus our attention for a part of the time on that vastly important period of two to six. Up to quite recently this strategic period has been solely within the scope of the pediatrician and not the psychiatrist. As psychiatrists we feel that the problems of these years are within our territory, and that with a psychological background, as well as a medical one, we can be of real service in this field. We feel that it is not a problem for the psychiatrist alone nor the pediatrician alone, but for both, working together.

Our knowledge of adult psychoneuroses has given us a better understanding of the psychological twists of childhood. There is reason to think that there are conflicts present in childhood which give rise to psychoneuroses similar to those of adults, possibly more simple in their structure. In looking more especially at habits, we do not feel justified in arguing that the presence of an unusual habit in childhood bespeaks an adult psychoneurosis or psychosis, yet we do feel justified in saying that many of these habits are indications of an emotional instability, which, if allowed to develop undirected, may well make for an inefficient adult adaptation. Failure on the part of an adult to adapt himself properly gives us alcoholism, drug addiction, delinquency, prostitution, convulsions, and a variety of other abnormal modes of meeting the tasks at hand. We feel that these reactional make-shifts may often be traced back to an inefficient reaction—a habit in childhood. If these conflicts—these poor adaptations to reality—can be met and coped with at four instead of forty, what a vast amount of discomfort—personal, social, and economic—we have saved the patient, his family, and the state. We are willing to rest our argument with this superficial indication of our position, feeling assured that you are in agreement as to the vital importance of the two to six period. Also I feel sure that in Dr. Catton and Dr. Harvey's consideration of these problems the connection between childhood mal-adaptations and behavior problems of later life will be stressed.

We are bringing to you a report of work accomplished in Oakland and in Berkeley, where we are unusually fortunate in having the necessary equipment and facilities for work, and where at the present time we have a fairly satisfactory child guidance machine—a group of clinics at the Oakland Health Center, at the Oakland Baby Hospital, and at the Berkeley Health Center. Each of these clinics is provided with adequate space, proper surroundings, social service workers, a psychologist, and close contact with an established group of specialists for reference work. We feel that we may be justly proud in being able to present a working organization to the National Mental Hygiene Committee, and I believe the first real effort of this sort in Northern California.

We are modeling our work largely along the lines of the work done in the state of Massachusetts by Douglas Thom, where the name "Habit Clinic," to the best of our knowledge, was employed for the first time. The beginning was made in the city of Boston in a most unpretentious manner about two and one-half years ago. A large part of the work at first was done personally by Dr. Thom, later junior workers were drafted from the Boston Psychopathic Hospital, including a psychiatrist and a psychologist. The work has spread from this rather inconspicuous beginning and is now reaching well into the state. The ground for this work has been especially well broken in Massachusetts by a very complete and carefully executed program of mental hygiene. The first habit clinic in Boston included, as Dr. Thom points out, "a psychiatrist one afternoon a week, a pad of paper and pencil, a chair and table in the nursery, and the necessary equipment for making a complete physical and neurological examination."

Work not dissimilar to this had been done earlier in New Haven with Gessell, and I believe also in New York. But I think that we are correct in saying that the term "Habit Clinic" was employed in the Massachusetts undertaking for the first time.

What is the scope of a habit clinic? The province of such a clinic is to consider and treat improper modes of dealing with childhood problems—that is, within the period of two to six years. Also, we should include within this scope an attempt to aid in the formation of habits which will be of use in developing a well-rounded adult personality. To be specific, what are typical situations to be dealt with in a habit clinic for pre-school children? First, we have faulty adaptation to the feeding situation—vomiting when certain foods are given, rumination, regurgitation. Then we have faulty sleep habits—night terrors, sleep-walking, sleeplessness, bed-wetting. Masturbation is one of the most frequent of our problems. Dirt-eating, thumb-sucking, lying, cruelty, speech defects, day-dreaming, tics, undue affection for a member of family mannerisms, are but to mention a few of our situations.

To be more specific, I can summarize a few cases recently encountered.

Case I—Boy, aged 5. Complaint: Bed-wetting, running away from home, facial and nasal tic. As to the bed-wetting, we find that he is given water and tea in abundance at a late supper, is not sent to the toilet before retiring, and is scolded continually about this shortcoming. We try to cut out the scolding and to change the dietary and sleeping situation. As to the running away, we find that the child has an excessive fear of the father, induced by too frequent punishment, often considerably delayed after the offense. Due to this delay, the child has stored up a fear and a resentment for the father, and gets away from home when the father is about. The facial and nasal tics are on a physical basis in part. The child has large tonsils—a mild rhinitis is induced, the infection ascending to the eyes where a mild blepharitis is caused, the constant irritation in the nose causing the snuffing, and in the eyes the blinking. A removal of the tonsils has largely remedied this condition. Imitation also

plays a part here, for we find that the patient's older brother had a similar habit.

Case II—Boy, aged 5. Complaint: That he soils himself in kindergarten. In this case we find physically an underdeveloped child, with poor muscular tone. As a baby, and even later, we find that the mother worked out and the boy was left to the tender ministrations of an older sister. Very little attention was given to the bowel movements, and the child was not taught to go to stool at regular intervals. Our present trouble is largely a continuation of this untidy habit developed during babyhood.

Case III—Boy, aged 6. Complaint: Masturbation. Here we find a rather long foreskin with difficult retraction and evidence of irritation. Our first step is circumcision. We changed from a nightgown to sleeping-suits, and arranged for the child to sleep alone. We have also arranged that the child is not to be put to bed until there is evidence that he is sleepy; heretofore, the youngster going to bed immediately after dinner, before he was sleepy and lying there fully an hour before he went to sleep—a golden time to foster the habit we are trying to overcome.

Case IV—Girl, aged 5. Complaint: Stammering. The child had been somewhat slow in learning to talk. This was a source of annoyance to the parents, and they constantly urged her to talk, scolding her at times for being slower than their other children. Some well-meaning teacher told the mother to make the child repeat sentences as fast as possible. This was tried and the child's defect became much more pronounced. In our clinic treatment, we changed the type of therapy to include deliberate pronunciation and breathing exercises, and tried to establish the necessary rapport between the child and the examiner.

These cases I have summarized, not because there is anything very spectacular or remarkable about them, but rather to show you the type of thing we encounter in our habit clinic work, and to emphasize the types of disorder which we feel are worth remedying. We feel that therapy along these lines can make the difference between a normal adult and an adult defective in some emotional respect, possibly a dependent on state or county.

ORGANIZATION AND TECHNIQUE OF A HABIT CLINIC

In the first place, to my mind, the setting of such a clinic should be given most careful consideration. I feel very strongly that it should be located in an established clinic or nursery. For the proper handling of a clinic one needs the constant proximity of specialists in other lines, the internist, the surgeon, the oculist, and so on. A dentist also is an essential part of the general clinic personnel. The actual clinic surroundings should be carefully considered, so that as far as possible the child is freed from the usual terror of white-walled hospitals and outpatient departments. Ordinary nursery accessories should be in abundance—sand pile, toys, books, games, and, if possible, a competent director for these activities. While I feel that to a certain extent it is valuable to keep before the child the fact that he is coming to the physician for a purpose, yet we do want him to come in to us from as near a normal environment as we can provide. Toys in the examining room are useful at times. Small chairs and a small table are worth getting. Needless to say, examination paraphernalia should be inconspicuous.

We find it more satisfactory to discuss the situation with the parent before seeing the child (leaving the child with a nursery attendant). Then to have the child in with the parent, adhering largely to commonplaces rather than going directly to the situation in question, or giving the mother an opportunity of covering the situation before the child, emphasizing, as she all too frequently tries to do, the fact that her child is a "nervous child," how he annoys the family, how many other members of the family have suffered from nervous complaints and such-like data, which, of course, tends to make the situation worse as far as our patient is concerned. Then, after a degree of rapport has been established, we like to see the child alone for a few minutes; this is not always accomplished until the second visit. These visits alone with the child, we feel, are of real value and often give us the clue to the situation. These sessions are of real therapeutic value, and it is a satisfaction to find that your small patients come to look forward to their clinic visits, and pride in the week's attainments prove of no small value in habit correction.

There is, of course, no deep mysticism or any subtle psychiatric procedure employed, but only an attempt made to dispense common sense in small doses. Usually, the mother must be very carefully instructed in the things to do, and more important, in the things not to do. And, most important, the social service worker or the visiting nurse should make repeated home visits to see that such instructions are followed. In many of our cases the cleaning up of the home situation automatically clears up the habit situation.

After dealing with the parent, the situation is gone over in as simple a way as possible with the youthful patient, pointing out frequently that the reaction complained of is immature, and not worthy of him. We try to dispel the all too frequent belief of the child that his habit is something of dire moment and consequence. We explain to him that, although it is not entirely admirable, yet it is not of the greatest importance and that we fully expect that it will disappear. Sometimes we outline simple lines of therapy for the child, breathing exercises, co-ordinating muscle movements, simple dance movements. Then, most important, we outline a program of positive attainments and aim at the establishment of a useful set of habits. A program of helpfulness in small duties about the home, conduct in kindergarten and in the playground is covered.

In outlining these positive situations, we are keeping in mind several salient points of child psychology, which we feel are worth mentioning in passing. These are: (1) Reasoning power of the child; (2) ability to imitate; (3) ability to accept and act on suggestion; and (4) the need of approval.

The power of reasoning in young children, especially in infants, has been a source of discussion for years, and we only want to point out that beyond doubt we give a young child credit for all too little intelligence. His mental processes are far ahead of his powers of speech, as anyone can verify who has had opportunity of watching children. In the practical management of children we find that an appeal to reason is often useful before a child can express himself. For this reason, it is poor policy to feel that we can fool a child with any silly explanation that comes to mind. It is much safer to err on the side of crediting him with too much intelligence rather than with too little.

As to our second point—the ability to imitate. This ability can be used as a real aid in building up a set of good habits and shaping a satisfactory character. A cheerful, bright, alert, interested mother will, in most cases find the same sort of child, whereas a surly, scolding, nagging mother cannot complain of a nervous child. If the family clothes are thrown hit or miss about the room on retiring, one cannot be surprised if Johnnie's clothes are likewise distributed. If the sleeping and eating habits of the family are slovenly, one must look for similar habits in the small boy of the family.

Our third attribute—the ability to accept and act on suggestion—is possibly our greatest asset in dealing with the problems of the nervous child. With ordinary suggestion, tactfully applied, we can induce habits of orderliness and precision in a child without any great deal of difficulty. It cannot be done immediately, but every success makes the next attempt less difficult. Suggestion is a real factor, if well used, but without common sense is useless. By this we mean, that, if a child of four is busily engaged in pulling the cat's tail, a mere soft-voiced suggestion that he stop this fascinating sport and come to dinner will not suffice, and, if anything, makes the situation worse. If, on the other hand, when his attention can be gotten, it is suggested to him that some other pursuit—eating his meal—is just what he most wants, his attention is taken from the cat, not focused upon it as it was in the first place, and the beginning made for a new and beneficial association. As has been pointed out in the case of army orders, the men are brought to attention before the order is given, not issuing it while their attention is on some other move.

Our fourth and last outstanding point is that very prominent desire for approval that every normal child manifests. Approbation and desire to hold the center of the stage play no small role in juvenile psychology and must be taken into account. Every child craves a certain amount of credit for work well done, and a well-rounded character will not result if this is not obtained. Too free an approbation is bad, but just praise well-applied helps more than the hair-brush. No child should be given a free lease on the center of the stage, but focusing family attention on the child, in moderation, is helpful. A too frequent repetition of the adage, "Children should be seen and not heard," is the cause of no few nervous disorders, and is conducive of a seclusive, shut-in make-up, which forms a breeding place for subsequent difficulties of adaptation.

We feel that the physical consideration should be large in habit cases. To be concrete, we feel that circumcision should be advocated at the least sign that it is needed. In normal children, we may frequently disregard this necessity, but with the nervous child, even a slight source of irritation may be enough to swing the pendulum in the wrong direction; consequently, circumcision may be neurologically indicated when it is not surgically so necessary. Tonsils and adenoids must go, with an accompanying removal of a variety of facial tics. Eyes should have early attention if there is any indication of muscle trouble. The orthopedist must frequently be consulted as to posture and deformity. Focal infections should not be forgotten, although we do not feel justified in cottonizing many of our diminutive patients. Nutrition, too, is to be seriously considered.

A psychologist is an essential part of our clinic. For routine—Binet's—we care not a whit, but for intelligence tests, applied by a good medical psychologist, with an ability to interpret, results in light of special abilities and disabilities we have every respect and look to as a valuable adjunct of our clinic.

Frequent conferences should be arranged to include the psychiatrist, the psychologist, and the social service worker. This point cannot be overemphasized, for, without the fullest co-operation and understanding between these three viewpoints, we cannot hope for the fullest accomplishment of our aims.

In closing, then, if we may sum up the points considered. We have looked briefly at the development of the habit clinic idea in this country, with especial reference to the work in Massachusetts. Our next consideration was a general survey of a habit clinic, with resumés of typical cases. Our final division was a view of the actual mechanics of running a clinic, and our mode of procedure. I should like to close this paper with the words of former Chief C. Macfie Campbell:

"For the nervous child two conditions are eminently salutary: First, a wholesome objective regime, and second an atmosphere of frankness, in which he can get a fair chance to discuss his troubles."

1904 Franklin Street.

A Method of Demonstrating Tubercle Bacilli in the Urine—In the method described by Stephen G. Jones, Boston (Journal A. M. A., December 13, 1924), a catheterized specimen of urine is centrifugated at lowest speed for two or three minutes, thereby removing the bulk of the pus and detritus. The supernatant cloudy fluid, containing a few pus cells and the bacilli, is poured off, one-half is discarded and the remaining half is poured into a second centrifuge tube. To this half-filled tube, one-quarter volume of 95 per cent alcohol is added, the remaining quarter being distilled water. This mixture is centrifugated at highest speed for forty-five minutes until clear, the supernatant fluid discarded, and a smear made from the sediment obtained with a flamed wire loop. The smear is allowed to dry and is then fixed by being passed rapidly two or three times through a Bunsen flame. The centrifuge must be an electrically driven high speed machine. When carrying a load of four tubes, it should make from 2000 to 2100 revolutions per minute, which produces a force 1077 times that of gravity. The Ziehl-Neelson stain is employed. A more delicate stain is obtained if a steam bath is used rather than heating the smear with the direct flame. This is easily accomplished by placing the glass slide over the open top of a can containing steaming water. In this way the stain is heated sufficiently without danger of precipitating the dye. Twenty minutes suffices. The preparation is decolorized by exposure to 30 per cent nitric acid, followed by alcohol (Czaplewski's solution) or to 20 per cent sulphuric acid. The pitfalls are that occasionally nitric acid and alcohol may not decolorize all acid-fast bacilli other than tubercle bacilli. Twenty per cent sulphuric acid will decolorize all other acid-fast bacilli, but may also decolorize tubercle bacilli. The decolorized smear is washed with water, and counterstained with methylene blue. Several hours' search will often disclose the solitary group of bacilli which otherwise will be missed.

Adam and Eve were perfectly happy and sweetly contented in the garden of Eden until Satan's prescription was taken and they beheld their naked condition and Eve began making garments of fig leaves and both of them were ashamed of themselves.—Austin Flint (Iowa Medical Journal).

THE PNEUMONIC PLAGUE IN LOS ANGELES

By Emil Bogen, M. D., *Los Angeles*

A story of the recent epidemic which demonstrated the effectiveness of intelligent health work.

ON OCTOBER 29, 1924, a physician called up the Los Angeles General Hospital to say that he had just seen a Mexican patient who appeared to be critically ill of some malady which he could not definitely diagnose, but which he thought might be highly contagious, since several others in the neighborhood were similarly affected, namely, with a very high fever and pains in the back and chest. Accordingly the ambulance was sent to a Mexican settlement on the outskirts of Los Angeles, where a group of people were found clustered in front of a one-story frame building with a little porch and a single front room.

In the middle of this room an old Mexican woman was lying on a large double bed, crying between paroxysms of coughing, while along the wall was a couch on which was seen a Mexican man of about 30 years of age, restless and feverish, but not coughing. There were several other persons of both sexes in the room, one of whom volunteered to act as interpreter. With his aid, it was learned that the man had been stricken the preceding day with a severe pain in the front of his chest and along the entire spine, and had had a fever, which at that time was 104 degrees, and a few reddish spots on his chest, but no other symptoms of note. The old woman had apparently been previously stricken in the same manner, but she had been coughing for the past two days, expectorating a profuse bloody sputum, and had loud, coarse rhonchi in her chest.

While these two patients were being placed in the ambulance, the interpreter led to a house nearby, where he said there were some other patients with the same disease. Here a young man was found in bed, suffering with a high fever and pain in the chest and back, but no other symptoms. In an adjoining room his wife, also feverish, stated that she was feeling better than previously, while in the front room a young girl sitting in a settee, with her head in her hands and with a flushed face, insisted that she was not sick, only a little tired. (Three days later the man was dead, and the two women were dying in the hospital.) The interpreter remarked that four other boys, relatives of our patients, were ill at this time in their home a few blocks away. He added that the father of the man we had come for had died in the hospital a week ago of what was thought to be pneumonia, and that the mother had died a week before that with similar symptoms.

The four boys were brought to the hospital that same night, and during the following day six more cases were admitted from that neighborhood. Soon after admission they developed signs of a severe pneumonia, with bloody expectoration and marked cyanosis. During this day three of them died, and that afternoon the diagnosis of pneumonic plague was first suggested. The following morning Dr. George D. Maner performed an autopsy on one of the patients who had succumbed, and reported that smears from the lungs of the patient showed Gram-negative bipolar staining bacilli characteristic of plague.

During the next six days twelve other Mexican patients were admitted with the same condition, but deaths followed so rapidly that, by the end of the week, out of the entire group there were only two boys left alive, and one of these passed out during the next week. Seven other patients have been reported to have died of the same disease without entering the hospital, making a total of thirty deaths from the pneumonic form of plague during the two weeks in Los Angeles.

On October 31, the day that the organism was first found, a nurse who had been caring for the first victim during his few hours in the pneumonia ward the previous week was admitted to the hospital, suffering with a severe pain in the chest and back and a fever which she said had been coming on for two days. Soon she developed difficulty in breathing, coughing and expectoration, which on the following morning was blood-stained, and a large, painful swelling of the glands of the neck. As a desperate resort, she was given 30 cubic centimeters of a 1 per cent solution of mercurochrome intravenously, and during the week received several additional injections, with noticeable improvement in her condition, and appears at the present time to be proceeding towards convalescence. As yet, however, no bacteriological confirmation of the diagnosis has been secured in this case.

As soon as the disease was recognized steps were taken to prevent the spread of the epidemic. The district within which the cases originated was placed under quarantine, and all persons known to have been in contact with patients were observed carefully for the next ten days, the maximum expected incubation period. An organized campaign was inaugurated against rats. At first everyone in the hospital wore a clean gown, cap and gauze mask whenever he entered a room in which a plague patient was being cared for, but this was deemed insufficient protection, and so masks were made consisting of a pillowslip which was placed over the entire head, a small piece being cut out for the eyes, which was replaced by a piece of transparent celluloid attached by means of adhesive plaster. Procuring and working in these masks was a matter of considerable exertion, and also of considerable comment and divertisement.

Meanwhile about a score of patients had been placed in the contagious building, with a diagnosis of "suspected" plague which could not be confirmed. A number of these were proven at autopsy to have died from some other condition, while the subsequent clinical course of the others tended to clear up the diagnosis. One case of pestis minor, however, with a bubo which proved on aspiration to contain organisms of plague which were confirmed by animal inoculation experiments, was found in this group.

On account of the prostrated condition of most of the patients and the difficulties incident to caring for such an unexpected and dangerous disease, the histories and records are necessarily incomplete and inadequate, but the following data regarding the twenty-four patients who died of pneumonic plague

at the Los Angeles General Hospital may be of interest. In every case a history of close contact with a case previously stricken could be secured. The average duration of the illness before admission to the hospital was between three and four days. The average length of hospital treatment was less than two days, but one case was proven plague at autopsy after twelve days of hospitalization.

The chief symptoms complained of, in the order of frequency of occurrence, were fever, ranging from 100 to 106 degrees on admission, expectoration with blood-stained sputum, cough, pain in the chest, headache, generalized pains, vomiting, pain in the back and upper abdomen, malaise, epistaxis and chilliness without rigor. The main findings on physical examination, in the order of frequency, were large, coarse rales in the chest, thickly coated tongue, reddened throat, dyspnoea, impairment of percussion note over the chest, restlessness, prostration, delirium, weak rapid pulse, cyanosis, a systolic murmur, localized adenopathy, conjunctival injection, increase in spinal fluid pressure, with signs of meningismus in the children, jaundice and a macular rash.

Unfortunately, only nine of the bodies were autopsied before cremation, all of whom showed typical findings of a confluent bronchopneumonia in widely varying degrees, with the signs of a very severe infection, and the recovery of the bacillus of plague from the lungs and other organs, as proven by guinea pig inoculation. Blood cultures from nine other patients, however, also yielded this organism. In the remaining cases no bacteriological studies were made, but the clinical history and course of the disease, as well as the evidence of transmission through them to other patients, leaves no doubt as to the diagnosis. Smears from the sputa in a number of instances showed Gram-negative bipolar staining bacilli, with comparatively few pus cells.

In addition to repeated stimulation and other symptomatic treatment which all of the patients received, more than half of them received intravenous (or intraperitoneal) injections of mercurochrome, including the nurse and the boy who still survive, but fresh anti-plague serum was secured only in time to be used in one case. Since no new cases of pneumonic plague have developed for four weeks, it is believed that the epidemic is over, though sporadic cases of the bubonic type may still be expected to appear occasionally.

What's in a Name—Occupational therapy is now a classical remedy for ennui. It used to be called "work." The new name makes it more effective. An unfriendly dame suggests the installation of an old-time tread mill in every home as an economic proposition. It would serve both as a domestic power plant and an efficient substitute for cow pasture pool.—Kansas Medical Journal.

As an Editor Sees It—"Doctors who specialize are valuable. They push the science ahead. They do things that non-specialists could not do. But progress in one direction is paid for by loss in another. We are losing the first-rate all-around general physician and consultant. Properly speaking, the specialist should only be an assistant to the general physician, called upon when required."

ADENOMA OF THE THYROID *

By VINTON A. MULLER, M. D., *Reno, Nevada.*

A clinical study for clinicians.

The treatment of adenomas is surgical. Iodine is contra-indicated.

The use of the x-rays in this type of goitre is to be condemned.

DISCUSSION *by W. W. Washburn, San Francisco; M. R. Walker, Reno, Nevada; Raymond St. Clair, Oakland; Thomas Wilbur Bath, Reno, Nevada.*

THE adenomatous goitre, which is the most common type of goitre, produces thyroid enlargement by the growth within the substance of the thyroid gland of encapsulated adenomas, which may be either single or multiple, and which give rise to the condition frequently spoken of as nodular goitre. The true etiology is as yet unknown, though it is quite commonly believed that some of these adenomas take their origin in cases of long standing colloid goitre, whereas others are believed to develop from foetal rests.

Adenoma of the thyroid ordinarily makes its appearance between the ages of 15 and 20, although some of these growths are first noted later on in life. The average age of first appearance is 22. Clinically, it is characterized by an asymmetrical or nodular enlargement of the thyroid gland caused by the presence of single or multiple growths, which may be confined to one lobe, both lobes, or any portion of the gland. At times these goitres may be retrosternal and not particularly visible in the neck or, in addition to the enlargement in the neck, one may find that one or more of the adenomatous masses descend behind the sternum and into the mediastinum. Asymmetry, though usually present, may not be marked, and occasionally only the most careful palpation will reveal the presence of a tumor mass or multiple masses within the gland. To the palpating finger the consistency of an adenoma is usually harder than normal thyroid tissue, but where degeneration has taken place the consistency may vary from the fluid of cyst formation to the hardness of calcareous deposits. Degenerative changes are prone to occur and are usually the result of hemorrhages within the capsule of the adenoma, and give rise to the various clinical varieties, such as hemorrhagic goiter, cystic goitre, calcareous goitre, etc. Myxomatous and hyaline changes also occur. In case of sudden enlargement, one must always think of hemorrhage; in case of rapid growth, malignancy.

In the early stages of their development these goitres do not produce symptoms except when their location is adjacent to an important structure whereupon pressure symptoms may develop. These pressure symptoms will depend upon what structure is involved, and are commonly manifested by difficulty in breathing or swallowing. Large retrosternal growths may interfere with circulation, produce a caput medusa or other signs of mediastinal obstruction.

About sixteen years after the appearance of the adenoma within the thyroid symptoms of hyperthyroidism may develop. The average age of appearance of these symptoms is thirty-six and one-half

* Presented before the Twenty-first Annual Meeting of the Nevada State Medical Association.

years, though at times young patients twenty-eight and thirty will come in mildly toxic. The cause of this hyperthyroidism is due to the secretion of normal, or nearly normal, thyroid hormone in excessive amounts by the adenoma. In 1916, Goetsch believed that the mitochondria in the adenomas were increased when hyperthyroidism was present, and offered this as a means of differentiating pathologically between adenomas with and those without hyperthyroidism, but his work has not been confirmed. In 1920, Boothby stated that, pathologically, there was no difference between an adenoma with and one without hyperthyroidism. In 1922, Wilson found that in the adenomas with hyperthyroidism there was evidence of increased activity of the parenchymal cells, which was indicated by moderate degrees of cell hypertrophy and hyperplasia which was not present in adenomas without hyperthyroidism. He concludes that the symptoms of hyperthyroidism occurring in these adenomatous glands are caused by the absorption of complete thyroxin in previously stored colloid, which is being manufactured more rapidly than in a normal gland, but much more slowly than in the gland of exophthalmic goitre.

These symptoms of hyperthyroidism are evidenced by nervousness, tremor, tachycardia, loss in strength and weight, with a tendency to hypertension and, in the later stages, myocardial degeneration. This type of goitre has a more pronounced selection for the cardiovascular system than exophthalmic goitre, and the changes produced are gradual, progressive, and certain. These patients appear for examination on an average of nineteen years after the first appearance of the goitre, and three years after the onset of their symptoms of intoxication. Nervousness and tremor are always present, but to a less degree than in exophthalmic goitre, whereas the cardiovascular symptoms are more pronounced; and it is not especially infrequent to see patients with oedema of the feet and ankles with all the symptoms and signs of cardiac decompensation who have been treated for cardiac decompensation "and the small, nodular goitre, which has been there for years without causing any trouble," overlooked. The tendency to hypertension is greater than in Grave's disease. Both systolic and diastolic pressures are greater than in Grave's disease, and this is true both for office readings and bedside readings, although in my own personal experience cases of Grave's disease seem to have higher systolic pressures than toxic adenomas. The basal metabolic rate is increased in the toxic adenomas, but this increase is to a less degree than in Grave's disease. The average B. M. R. in 201 cases studied by Boothby was plus 28.

The treatment of adenomas is surgical. Iodine is contra-indicated. Its use exerts no influence in causing the adenoma to disappear, but, to the contrary, it may cause symptoms of hyperthyroidism to develop; a condition which was often called by our predecessors "iodine heart."

The use of the x-rays in this type of goitre is to be condemned. They do not relieve the patient of her adenoma, but may relieve her of what normal thyroid tissue she has left and thus give rise to symptoms of hypothyroidism. The adenomas often crowd out and obliterate the normal thyroid tissue until there remains only a thin layer of it adhering to the capsule of the gland which might be just enough to care for the patient's needs after her adenoma is removed. In some of the adenomatous goitres that appear diffusely enlarged, an x-ray treatment will cause the adenomatous nodules to become apparent by its selective action on the extra adenomatous tissue.

Cleaning up of foci of infection seems to have a beneficial influence in Grave's disease, but will not exert any effect in causing an adenoma to disappear.

To remove the adenoma surgically is to remove abnormal thyroid tissue, which, by its presence, produces all of the patient's symptoms. Its surgical removal will put a stop to the disease, but whatever permanent damage to vital organs has occurred will always remain. Even the extreme cases, however, will show some improvement after operation. Removal of the goitre before symptoms arise preclude their possibility; removal after they appear, arrests the disease, prevents further degeneration and allows for some recuperation. The B. M. R. returns to normal limits within two weeks following removal of the adenoma. In contra-distinction to Grave's disease, these patients do not require the pre-operative preparation that those suffering with Grave's disease do—the advanced cases with myocarditis, auricular fibrillation and hypertension, naturally require preoperative rest in bed and digitalis, until such time that they may be able to withstand thyroidectomy. Preliminary ligations are never done. It is essential that we recognize adenoma of the thyroid and remove them surgically before permanent damage to vital organs takes place. It is not good judgment, however, to advise surgery in young people from 15 to 25 years of age without symptoms, on account of the possibility of new adenomas developing after operation or very small ones being overlooked at the time of operation, to subsequently grow and give trouble. A frequent site of such "recurrences" is the pyramidal lobe, and for this reason it should be removed at operation, providing there is enough normal thyroid left without it.

A further, but also important, reason for advising surgical removal of adenomata of the thyroid gland is that 95 per cent of cases of carcinoma of the thyroid occur in glands with pre-existing adenomas, and, although carcinoma of the thyroid gland is rare, we can readily see that it may be made rarer by curing our patients of adenoma.

Gray-Reid Building.

DISCUSSION

W. W. WASHBURN, M. D. (380 Post Street, San Francisco)—I am glad that Dr. Muller has chosen to speak upon a distinct type of goitre rather than attempting to cover a large field. He is to be commended for this excellent paper, treating with adenoma of the thyroid.

The importance of first establishing an accurate diagnosis cannot be too strongly emphasized, for upon the diagnosis depends proper treatment. We still continue to see altogether too many goitres treated in a sort of "routine" manner. If iodine doesn't help, X-ray is tried, and when medical measures fail some of these patients are told that nothing more can be done except a "dangerous" operation. And, too often, I am sorry to say, the general practitioner attempts treatment of these too long, before referring them to one familiar with goitre problems. One still continues to see a great many adenomas of the thyroid treated along medical lines, especially the x-ray. This is because either an accurate diagnosis has not been

made, or else the physician is not aware that adenomas are neither cured nor benefited by x-ray therapy.

When seeing a young woman in the second decade of life presenting definite adenomas of the thyroid and symptoms of hyperthyroidism, before attributing this hyperthyroidism to an overfunctioning adenoma, one should suspect an associated hyperplasia in the remaining gland, as ordinarily the adenoma does not put out increased amounts of thyroxin until it has existed a number of years. True exophthalmos does not occur with toxic adenoma, and when present means a hyperplasia. A definite bruit heard over the thyroid gland proper, especially in the upper poles, is pathognomonic of hyperplasia. Toxic and non-toxic adenomas do not give a bruit upon auscultation, nor a thrill upon palpation.

The importance of exposing the entire gland at operation and palpating same cannot be too strongly emphasized. The full Kocher collar incision should be used in all cases, particularly when operating for adenomata. Recurrences after operation are generally due to overlooking small adenomas at the time of operation.

In reference to pressure symptoms from adenoma, I wish to call attention to the fact that we should not overlook some of the pressure signs. Chief among these is unilateral laryngeal palsy, which may have come on so gradually as not to have caused distinct voice defects, due to compensatory reaction of the opposite vocal chord. A pre-operative laryngoscopic examination will readily disclose the presence of such conditions, and relieve one of the embarrassment of having a voiceless patient, in case the opposite laryngeal nerve is accidentally injured in the course of operation.

As pointed out by Dr. Muller, why not operate upon these patients in the earlier stages, when the operative mortality is practically nil, rather than wait until they become poor surgical risks, due to a badly damaged myocardium?

M. R. Walker, M. D. (Gray-Reid Building, Reno, Nev.)—We all enjoyed this paper; it is brief and to the point. In our state, goitre is very common; apparently, at least, on the increase, although we have no reliable statistics to refer to. Diagnosis is not always easy, yet absolutely essential, if we expect to benefit our patients with any line of therapy.

While there is no question that surgery is the choice, there are numerous patients that, for one reason or another, will not submit to an operation. With such I have found that radiation will give at least symptomatic relief; especially is this true for relief from toxicosis.

Again, I observe that operation is by no means always satisfactory. I have recently had two patients who are now regretting that they submitted to an operation; one of them, within forty-eight hours after the operation, developed severe tetany. It is now over two years and no indications that we may stop treatments for tetany. This operation was performed by an able surgeon. The other patient has become asthenic and has developed a marked irritability of the heart, and, in spite of all I have been able to do, she has not regained sufficient strength to do her housework with any comfort—only two in the family at that. I have found that often the giving of thyroid or parathyroid is of advantage.

I feel that we should urge prophylactic measures more strenuously than we are in the habit of doing.

Raymond St. Clair, M. D. (Medical Building, Oakland, Calif.)—Dr. Muller is to be congratulated on his paper.

In the simple adenomatous goitre, it has been my experience that the diagnosis is comparatively easy. It is in the mixed type that we have difficulty in arriving at the right diagnosis. I believe that in the majority of colloid goitres small adenomas are present in the gland. These on account of absence of symptoms are overlooked in the histories. In many of my patients who have come to me with adenomatous goitre with hyperthyroidism, I obtained a history of greater enlargement of the gland in the first years of their disease. In my experience the adenomatous type of goitre is not overlooked as often as the exophthalmic type, as many doctors who served in the late war will bear witness. In our organization there were three doctors who were suffering with exophthalmic goitre who had not previously been diagnosed.

I quite agree with Dr. Muller that surgical treatment, if done properly, is the one indicated in adenomatous goitre, and if done early, soon after the toxic symptoms are noted, before permanent damage has occurred, one's results are practically 100 per cent cure. There has been a great deal learned about treatment of goitre in the past fifteen years, and our results are much better now than at that time.

The pre-operative care of the patient suffering with adenomatous goitre with hyperthyroidism is extremely important. It is my practice to get patients in the best possible condition for the operation, which is similar to the preparation in exophthalmic goitre; that is, rest in bed, good nutritious food, and a competent, quiet nurse, and digitalization. In the extremely bad cases I use the Crile method, with which you are all familiar. I can recall at least two or three patients with extremely bad symptoms in which this method was entirely successful.

It is not necessary to say very much regarding the post-operative treatment in simple adenomatous goitre patients who have suffered but a short time from hyperthyroidism, as they usually regain normalcy very quickly; but in those patients who have suffered permanent injury to their heart, kidneys, etc., it is necessary to keep them under observation for a longer period of time.

In patients who have come to me after having received x-ray treatment I have found difficulty in operating, on account of adhesions about the capsule. In some instances the patients have claimed that their symptoms had increased following its use. I am not prepared to say whether there is or is not a possibility of destruction of the small amount of normal gland which we find in these long-standing cases of adenomatous goitres producing a hypothyroidism, which is not a pleasant thing to have.

Thomas Wilbur Bath, M.D. (Reno, Nev.)—It is always a privilege to listen to a discussion which affects public welfare. Formerly, appendicitis was discussed at nearly every medical meeting. Result: Today, most of the intelligent layity believe that the best place for a troublesome appendix is in the pickle-jar of the pathologist. Likewise, the public is becoming educated on such subjects as cancer, focal infections, and the better care of women in childbirth. Just now our efforts are directed along the line of goitre. Continuous discussion will increase our knowledge. For, as it has been well said, in a multitude of counsel there is wisdom.

Medical surveys that have been made in the United States and abroad have been illuminating, in that we have learned more concerning past geologic conditions, community inbreeding and localization of areas where goitre is endemic.

It is well to begin with a clear definition of the term goitre. Goitre means a diseased thyroid gland. There are many types of disease of this gland, but in the subject under discussion, as is well pointed out by Dr. Muller, the adenomatous is the most common of all. Just how many people in the United States have goitre we cannot say. But it is safe to assume that the number must be up in the tens of thousands. Every goitrous person is likely to become, unless aided, a serious deviation from normalcy. Why the disease is more preponderating among women we cannot say, unless it is the incidence of sex. There is an old saying in England concerning the child-bearing woman, that for every child she loses a tooth. That we would term a sex incidence. To the sex incidence we might ascribe the invasion of infection in women, which accounts for them having the first honors in goitres and bad gall-bladders.

In this connection, also considering the more underlying causes of goitre such as the deiodinization of endemic areas, we must always bear in mind the aggravating effects of such focal infections as bad teeth and tonsils. And especially that type of the shining sepulchre of bad dentistry known as the gold crown. The gold crown truly covers a multitude of evils. The constant drainage from the mouth into the cervical areas directly or indirectly affects the lymphatics of the thyroid, greatly contributing to heighten the pathology of the gland.

I think it will bear investigation that another contributing cause of enhancing goitrous conditions is child-bearing. Every wife is a possible mother. Parturition increases every normal function, and likewise sets in motion any abnormalcy. Repeated child-bearing will eventually wreck the frail life bark of the goitrous woman, and she will be lost upon the rocks of a destructive pathology. To her husband and friends who fail to correctly inter-

pret her condition, she is a neurotic; and she receives no sympathy because of her peculiar actions, when in reality the poor woman is traveling that vague borderland where illusions are real and distress is actual.

In summing up the treatment for this condition, as was well said by some of my confreres, the only treatment is surgical. The technique for this operation is now standardized. The mortality is much less than in appendectomies. The results, in the main, are quick and gratifying. Other therapy has been proved a failure. When the thyroid has become adenomatous, nature displays for common gaze her danger signal so that he who runs may read. And the interpretation thereof is removal.

DOCTOR MULLER (closing) — I shall endeavor to make my closing remarks brief, and will dwell only on a few of the points brought out in the discussion. One of the most important things, I believe, is the laryngoscopic examination, as mentioned by Doctor Washburn. In fact, this is of sufficient importance that it should be recommended as a routine procedure in the examination of all patients with adenoma.

The question of radiotherapy being contra-indicated in adenoma of the thyroid has been generally agreed upon. In those patients wherein relief has been afforded by this method of treatment, I would be inclined to believe that the symptoms of hyperthyroidism had come from an associated hyperplasia rather than from an overactive adenoma. It is a well-known fact that radiotherapy may exert a beneficial influence in toxic hyperplastic goitre.

Occasionally one does see poor results following surgery, but these instances are today so rare that they should not in any way influence the practitioner against advising surgery. If the adenoma is broken into and only partly removed, or if adenomata are overlooked and left in the gland to give rise to subsequent "recurrences," the result of operation will not be satisfactory. If all, or nearly all, of the normal thyroid tissue is removed with the adenoma, the characteristic symptoms of hypothyroidism will follow. Where we have large adenomata there is often very little normal thyroid tissue present. The adenoma is always encapsulated, and in operating one should exercise care to remove it wholly and intact with its capsule, but care should also be exercised to prevent the injury or removal of normal thyroid tissue. In those cases with small adenomata there may be quite an abundance of normal thyroid present, and this danger, therefore, becomes less. Injury to the recurrent laryngeal nerves and parathyroid bodies should not occur if one keeps within the capsule of the thyroid gland posteriorly, as these structures lie posterior to the capsule. Removal of the parathyroids or destruction of their blood supply which comes from the inferior thyroid arteries will result in tetany. Where tetany occurs, 10 cc. of a 5 per cent solution of calcium lactate in 100 cc. of normal saline should be given intravenously at once.

It is generally believed that focal infection or childbearing does not play any part in the etiology of adenoma of the thyroid gland. However, they are very important factors in some of the other types of goitre with which this paper does not deal. The foetal adenomata undoubtedly arise from Wolfler's rests, which are laid down in intrauterine life, whereas the adult type most probably arise from cases of long-standing colloid goitre. Although it is always desirable to clean up foci of infection, one should not expect to see any change in his cases of adenoma following this means of treatment.

"A matter that is neglected to a very large extent by all our medical associations and our medical colleges is that of ethics. We need more preaching and more influence that will bring about right thinking in the practice of medicine. We are altogether too prone to overlook breaches of ethics and propriety on the part of some of our members; and bad conduct on the part of a few reflects on the whole medical profession. Oftentimes unethical conduct is due to ignorance. Our colleges, societies, and journals devoted to medical practice," says A. E. Bulson (Bulletin A. M. A.), "should emphasize the importance of adhering to the code of ethics as laid down and accepted by the American Medical Association."

SURGICAL TREATMENT OF CHRONIC PEPTIC ULCER

By J. H. BREYER, M. D., *Pasadena*

Review of recent literature.

An attempt to determine the relative value of medical and surgical treatment.

Many ulcers heal without any treatment.

Recent ulcers should be treated medically; all other types should be given the benefit of thorough medical treatment until cure or chronicity is established.

After failure of medical treatment, surgical interference should be resorted to without further delay.

After convalescing from operation, patient should be turned over to physician for management.

Successful treatment of peptic ulcer requires combined judgment of the physician and the surgeon.

DISCUSSION *by Walter B. Coffey, San Francisco; Frederick A. Speik, Los Angeles.*

THERE is still wide difference of opinion between some physicians and surgeons, as to the value of surgical treatment in peptic ulcer. Much of the older literature written has become obsolete. A review of the more recent literature may help us to arrive at some definite conclusions. From it and my own experiences I shall attempt to determine the relative value of medical and surgical treatment, and the indications for each.

Our knowledge of ulcer has been greatly increased in the past ten years by the study of living pathology in the operating-room and by developments in the radiology. Autopsy studies have revealed that many peptic ulcers heal without any treatment whatsoever. Experimental ulcers in animals usually heal very promptly, in spite of the presence of one or more producing causes. Why some ulcers become chronic in man is still not definitely understood. The following explanations perhaps carry us as far as any toward the solution of the problem.

When the gastric or duodenal mucosa, lowered in vitality from any cause, is exposed to the digestive action of gastric juice the surface becomes eroded. The degree of erosion depends on the vitality of the mucosa and upon the general powers of resistance of the individual. The lowered local resistance may be due to some circulatory disturbance of the gastric or duodenal mucous membrane, to a trauma, or to a general or local infection. The lowered general resistance of the patient may be due to anemia, poor nutrition, or to some nerve strain, such as worry, that may influence the high acid content of the gastric juice and thereby be a factor in producing pylorospasm. The eroding action of gastric juice is nil in the absence of hydrochloric acid, but the mere lowering of the hydrochloric acid content does not diminish the peptic activity of the gastric juice. When the stomach does not empty itself in normal time, we have a prolonged contact of the acid gastric juice with the eroded area, as well as the irritating action of decomposing gastric contents. A true vicious circle is often established, the ulcer maintaining all the conditions that caused it.

The following conditions have a natural bearing on the history of an ulcer. Rebellious chronic ulcers are more frequent in males than in females. In young subjects there is less tendency for the ulcer to become chronic; in older individuals the reverse is true. The location of the ulcer has a distinct bear-

ing on chronicity. A pyloric or pre-pyloric ulcer is apt to be tenacious because of the spasm which it produces. Duodenal ulcer is about four times more frequent than gastric ulcer. One report states that, out of a total of 262 duodenal ulcers, 242 were located within five centimeters of the pylorus. Out of 633 cases of gastric ulcer at the Mayo Clinic, the ulcer was located on or around the lesser curvature 534 times, 85 were in the posterior wall, 9 involved the greater curvature, and 5 were in the anterior wall. Of those on the posterior wall, 8.2 per cent were in the pyloric third, 73.3 per cent in the middle third, and 16.5 per cent in the cardiac end. Seventy per cent of gastric ulcers, when healed, produce contractions which result in some degree of stenosis.

Healing takes place by proliferation of the connective and glandular tissues. The muscularis never regenerates. The continuity of the muscle fibers is interrupted by fibrous tracts, and the stomach wall loses its pliability. These connective tissue fasciculi eventually contract more or less. When the wall of the stomach has been perforated, or when the inflammatory process has reached the subserous layer, the peritoneum becomes irritated and protective adhesions with adjacent viscera result. Chronic gastric ulcers nearly always have craters; the majority of duodenal ulcers lack this characteristic. The old callous ulcer of the stomach, with hard indurated margins, is very apt to recur.

What is known of the etiology and pathology of ulcer indicates that all that medical or surgical treatment can accomplish directly, toward promoting the reparative process, is to remove such hindrances to healing as may exist. In the majority of cases where the ulcer is active the main object is to control the acidity and to place the stomach at rest by avoiding all causes of irritation. The general condition of the patient must be studied and improved. Food traumas are lessened by proper diet. Intragastric tension, fermentive processes, and prolonged gastric juice contact are reduced by abolishing stasis. All foci of focal infections must be cleared up. Efforts to reduce the nervous tension of the patient must be made by advising him as to errors in his social habits and daily routine. Psychic rest is as important as physical rest, in reducing secretory and motor disturbances.

A careful analytical study of the Sippy medical treatment compels one to admit that it meets all of the above conditions. It is rational and logical. It goes without saying that all recent ulcers should be treated medically, and all other types should be given the benefit of thorough medical treatment until cure or chronicity is established. Each ulcer case must be considered individually. Treatment should not be carried out with an empirical routine. A definite knowledge of all the facts must be obtained. The history should be very carefully gone into. A case that is of long standing, with a history of many recurrences, should be investigated as to the extent of the pathological process. It should be determined whether or not the ulcer is of the indurated, callous type, which experience has shown does not yield to medical treatment; whether the ulcer is situated at or near the pylorus, causing obstruction and deformity, which type, as a rule, cannot be completely healed by medical treatment alone; or whether any of the complications of ulcer, such as acute or chronic perforation, repeated hemorrhage, hour-glass stomach, or perigastric adhesions have already taken place.

If the diagnosis of ulcer can be made early a higher percentage of cures will result, but care must be exercised not to misinterpret the symptoms of a diseased gall-bladder or appendix for those of ulcer. The interrelationship between ulcer of the stomach or duodenum and disease of the appendix or gall-bladder should never be forgotten. It is as important to clear up the focal infection of appendix or gall-bladder as those located elsewhere.

With the above points in mind, the physician and the surgeon will get closer together in their treatment of ulcer. The cases will be classified, with regard to treatment, into more definite distinct groups. It is only after failure of medical treatment that surgical interference should be proposed, in which case it should be resorted to without delay, otherwise its benefits will be gravely compromised. Likewise, after convalescence from the operation, all cases should be turned over to the internist for thorough dietary management.

The most frequently employed operation for chronic duodenal or gastric ulcer is posterior short loop gastro-enterostomy, the stoma being placed at the most dependant portion of the stomach. In the absence of an organic obstruction, it is probable that a more or less immediate spasm of the pylorus follows the operation of gastro-enterostomy. This pylorospasm prevents the gastric contents from passing into the duodenum, and as a result the gastric juice and food pass in the direction of least resistance through the new opening. After healing of the ulcer is well under way, the spasm probably relaxes in the majority of cases, and more or less of the food again passes through the pylorus. The safety-valve action of the new opening prevents excessive intragastric tension. Food fermentation is prevented by freer emptying of the stomach, and the regurgitated bile and pancreatic juice bring about a neutralization of the gastric contents. In properly selected cases the percentage of cures has been augmented by further surgical procedures. The removal of the ulcer seems ideal and logical; the risk, however, is increased. The Balfour cautery method is the operation of choice when it can be done without too great danger or chance of resulting deformity. In ulcers of the callous type, situated near the pylorus, and in which the possibility of carcinoma must be considered, Billroth's No. 2 excision for ulcer, with posterior gastro-enterostomy, is the method of choice. Moynihan and others are extending this operation to all ulcers in the region of the pylorus, with very good results. The Billroth excision operation definitely accomplishes three things. It removes the ulcer, thus abolishing secretory reflexes as well as a potential cause of cancer; by removing the pylorus it eliminates pylorospasm; and by lessening, to a considerable extent, the secreting area of the stomach it diminishes the free hydrochloric acid. Excision of the ulcer, together with pyloroplasty, is an operation that is also in high favor. To carry out either of these last-named procedures, the patient

must be sufficiently strong to withstand a long and possibly depressing operation. Too much emphasis cannot be laid upon this point. When the patient's condition will not permit of a more radical procedure, a secondary operation at a later date may be necessary to produce the best results.

There is no doubt that ill-advised surgery has been performed, with disastrous results, upon patients who did not have either duodenal or gastric ulcer, and also that these patients had previously been treated medically for ulcer. However, it is often very hard to find evidence of an existing ulcer, even when the stomach and duodenum are exposed at operation. After the abdomen has been opened, and before doing any gastric surgery, a thorough general intra-abdominal examination should be made for other pathology, such as disease of the appendix or gall-bladder, especially when the presence of a definite ulcer is in doubt.

W. J. Mayo, in 1922, gives the operative results at the Mayo Clinic, as follows: Ninety-five per cent of duodenal ulcers are treated satisfactorily by surgery, 1 or 2 per cent requiring secondary operation. The operative mortality for duodenal ulcer is less than 2 per cent. In gastric ulcer, satisfactory results are obtained by a single operation in 85 per cent. By secondary operation the surgically satisfactory results are increased to above 90 per cent. The average operative mortality in gastric ulcer is about 3.5 per cent. Of the surgical failures, 50 per cent obtain satisfactory results by post-operative medical treatment, and the other 50 per cent he classifies as due to faulty mechanics requiring secondary corrective surgical procedures.

Gastro-jejunal ulcer is a complication which occurs in from 1 to 3 per cent of all gastro-enterostomies. The location of the ulcer may be on the suture line or in the jejunum near the stoma. The cause of the formation of these ulcers following gastro-enterostomy is still unsettled. They have generally been ascribed to errors in technique. The use of silk or linen sutures and the production of a hematoma by needle-pricks, clamps, or finger-bruising is to be avoided. Oschner believes these ulcers may be caused by placing the stoma at a place other than the most dependant portion of the stomach. However, these ulcers occur in the practice of surgeons whose technique cannot be questioned. W. J. Mayo treats jejunal ulcer following gastro-enterostomy by disconnecting the gastro-enterostomy and doing a Finney pyloroplasty.

Obstruction of the pylorus may be an end-result of ulcer. Ulcers located in the pyloric region, duodenal or gastric, may produce narrowing by cicatricial contraction, by inflammatory infiltration of the walls, by reflex spasm from irritation of the hypersensitive ulcer, or by adhesions, resulting from pyloritis or perigastritis, which may cause bends or kinks. Most writers agree that operation is imperative when an organic stenosis is recognized clinically. Vomiting and other signs of stenosis, due to pylorospasm and inflammatory swelling associated with an unhealed ulcer, must be differentiated. The hyperfunction caused by organic stenosis ultimately ends in atrophy of the mucosa and in decreased motility. This decrease in motility is followed by gastric dilatation. When gastric atony is present, the operation becomes more dangerous and convalescence will be prolonged. The power of recuperation of the individual has a definite relation to the age of the stenosis. One surgeon had thirty-six patients with stenosis sent to him for operation by two internists who believed in early surgical interference. In these thirty-six there was only one death, a mortality of 2.8 per cent. Twenty-four cases sent to this same surgeon, by other physicians who had temporized, were operated upon with nine deaths, or a mortality of 37 per cent. Gastro-enterostomy gives the best results in these cases of organic stenosis. It is the only procedure that can always be resorted to, no matter how marked the induration of the lesion or how extensive the peripyloric inflammatory process may be. The advantages claimed by some surgeons for pyloroplasty, gastro-duodenostomy, and pylorectomy are clearly counterbalanced by the rapidity of execution and the lesser danger from gastro-enterostomy. When malignant degeneration is suspected, then excision of the ulcer, combined with one of the plastic methods, should be done. Statistics show that 78 per cent of gastro-enterostomies for cicatricial pyloric stenosis have resulted in permanent cure; 16.5 per cent of the patients show marked improvement, being able to return to their usual mode of life, although requiring a more or less strict diet and some medical care; and 5.5 per cent show no remote benefit from the operation.

Hour-glass stomach often is the end-result of an ulcer which has been active over a long period of time. The great majority of these ulcers are situated on the lesser curvature or on the posterior wall. X-ray findings have verified the view that after the ulcer has perforated there is often a tendency to heal spontaneously, and it is in this effort at healing that contraction takes place. Contraction usually takes place in the transverse direction and at the expense of the greater curvature. Because of the extensive scar tissue and perigastric adhesions, the type of operation must be mechanically adapted to the situation and to the recuperative powers of the patient.

Hemorrhage is a frequent symptom of ulcer. It occurs in about 25 per cent of cases. Hyperacute hematemesis may occur in an acute ulcer or during the course of a chronic ulcer. Extensive hemorrhage is best treated by rest and medication. We have two valuable remedies in thromboplastin and in sodium citrate used intramuscularly. Surgeons generally maintain that serious repeated hemorrage is a definite indication for operation. Gastro-enterostomy is the operation of election, either alone or combined with the use of the Balfour cautery when the ulcer can be definitely located. By gastro-enterostomy distention is overcome, allowing the musculature of the stomach to contract. The condition of the patient is usually such that any more prolonged procedure is contra-indicated. In a case of serious hemorrhage, Bevan has advised a jejunostomy for the purpose of placing the stomach and duodenum completely at rest. Chronic hemorrhage should invariably raise the suspicion of gastric carcinoma or malignant transformation of an ulcer. The treatment

of choice in a case of suspected malignancy is resection.

Perforation is the most fatal complication of peptic ulcer. In the majority of cases perforation overtakes the patient in apparently perfect health. The diagnosis of the resulting peritonitis is easy, but an etiological diagnosis is often impossible. A differential diagnosis between a perforated gastric ulcer, appendicitis, and gall-bladder disease may be difficult; surprises at operation are not rare. All writers agree that operation is urgent; the results are infinitely better when operation is done within the first twelve hours. In the great majority of cases perforation produces collapse, probably due to reflex action. When the patient is examined at this time, the general condition will be found to be serious. The pulse is rapid and weak, respiration is superficial, the expression is one of distress, and the patient complains of severe abdominal pain, usually high up, although not invariably so, with other symptoms of peritonitis. This is the stage of shock, and is not a good time to operate. It is followed by a period of fallacious improvement which has been the cause of numerous mistakes in diagnosis and the loss of very valuable time. The period of remission is the time to operate successfully, and it usually lasts only a few hours. During this time the danger of peritonitis is slight, because usually a very small amount of gastric content has escaped into the peritoneal cavity. This period of remission is followed by the earlier disquieting symptoms. The face is sunken, pain becomes more and more acute, vomiting begins, the pulse is weak, and the signs of peritonitis are fully established. The pain is now often referred to the ileocecal region and is, therefore, mistaken for evidence of acute appendicitis. The purpose of the operation is to treat the peritonitis, as well as the ulcer with its perforation. Murphy stated that in case of peritonitis one should get into and get out of the peritoneal cavity as quickly as possible. This precept should be followed to the letter if possible. Closure of the perforation should be done as well as is possible, considering the very friable nature of the ulcer edges, to be reinforced by a piece of omental graft. If the perforation is at or near the pylorus, with a partial stenosis already existing which would be exaggerated by the sutures used in closing the perforation, a gastro-enterostomy is indispensable, unless a pyloroplasty is performed, following the method of Dr. H. H. Sherk. If the perforation is located on the anterior wall, simple suture alone will suffice. No extensive cleansing of the peritoneal cavity should be attempted. The peritonitis should be treated by drainage, local and suprapubic, by Fowler's position, and by saline injections.

CONCLUSIONS

Recent ulcers should be treated medically, and all other types of ulcer should be given the benefit of thorough medical treatment until cure or chronicity is established.

After failure of medical treatment, surgical interference should be resorted to without delay.

After convalescing from the operation, the patient should be turned over to the physician for management.

The successful treatment of peptic ulcer requires the combined judgment of the physician and the surgeon.

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DISCUSSION

W. B. COFFEY, M. D. (Medical Building, San Francisco) — My experience with the surgical treatment of peptic ulcer is that all patients with chronic indurated gastric ulcers should come to operation, and all those with duodenal ulcer should be studied by the physician for a trial period of two or three weeks, unless there are indications for immediate surgical intervention, like unusual hemorrhage, perforation or stoppage of the outlet of the stomach, evidently progressive, and recurrences of pain and bleeding, in spite of proper hygiene and diet.

Even retention of half a barium meal at the end of six hours should not be a signal for surgery, unless ten to fifteen days' trial of rest in bed and Lenhart diet have shown no change in the degree of retention. Many times the conservative course has shown that, as the ulcer heals, the retention is overcome and operation is unnecessary. When patients with recurrent history, whose ulcers break down in spite of proper living and careful observance of instructions, return a second time, surgery is considered at once, but is not carried out until it is demonstrated that there are no etiological factors likely to cause a recurrence.

Even the finding of occult blood for more than two weeks' treatment is not always indicative of the demand for surgery, as a number of cases have shown, where other factors made surgery undesirable. We have had to transfuse some cases, as many as three times before surgery was done, because of the failure of transfusion to stop hemorrhage or even slow oozing. I cannot wholly agree with the writer that there is a wide difference of opinion between good physicians and good surgeons, for the most satisfactory cases on which to operate are those in which the medical study has shown complications of a nature not to be relieved by medical treatment. Practical experience guides one to recognize the medical and surgical type of duodenal ulcer. "If the surgeon can cure 85 per cent of the medical failures, there seems to be no good reason for rivalry." All gastric ulcers are essentially surgical. Adhesions to the gall-bladder, low-grade pancreatitis, pain and retention, all make the type of complications which invite surgery.

One thing more, and that concerns the Sippy diet, which is open to two criticisms. Gastric lavage is not often necessary in ulcer therapy, and is not used in one per cent of our cases, and the use of soda and alkalis generally is absolutely unnecessary and pernicious as a routine measure. It is a poor and dangerous substitute for a proper diet which will regulate and provide for the acidity which is so frequent a symptom. Disguising *pain* is a doubtful method of treatment always, although at times justified.

FREDERICK A. SPEIK, M. D. (Auditorium Building, Los Angeles)—Dr. Breyer has hit the nail on the head. The physician and the surgeon should get together. There are cases which are amenable to medical treatment, and there are cases that need surgery. It is indeed very necessary that a most careful and painstaking examination should be made and backed by proper judgment.

In seventeen years of experience in this work, I feel qualified to say that the Sippy treatment is not merely giving milk and cream and powders, but that the treatment begins when the patient enters the office. We must not only diagnose whether or not an ulcer is present, but where it is located, how old it is, what complications are present.

When this is done we know what to do with the ulcer, i. e., treat it surgically or medically.

DOCTOR BREYER (closing)—The surgeon is apt to operate too quickly on his ulcer patient, and the physician is prone to hang onto them too long. By greater co-operation I believe this tendency will disappear.

I believe it is far safer to do gastric or duodenal surgery upon a patient who has been under preliminary

medical management, with rest in bed. The local condition of his ulcer will be better, and his general condition will be improved.

I think it is now generally conceded that all patients with chronic, indurated gastric ulcers should be treated surgically. However, gastro-enterostomy alone will cure only a small percentage of them. The radical resections should be reserved for those patients where the indications justify the risk of radical treatment. The last word in gastric surgery has not been said.

It is well to bear in mind the high percentage of cures achieved by well-established methods. By improving our technique, as well as by more carefully selecting our cases, we can still further increase this percentage.

AREA CHANGES IN HEARTS SHOWING DECOMPENSATION AND LOWERED CARDIAC RESERVE, WITH REPORT OF TWENTY CASES

By DONALD J. FRICK, M. D., ROBERT H. KENNICOTT, M. D., ROLLA G. KARSHNER, M. D., *Los Angeles*

Cardiac areas, as computed in the orthodiagram, show a fluctuation during compensation and decompensation.

In cases of lowered cardiac reserve, enlarged hearts are seen to decrease in size with clinical improvement.

In a small number of cases, subsequent enlargement of cardiac area accompanying clinical improvement and resumption of exercise would point to cardiac hypertrophy.

Correlation of cardiac areas and clinical findings give information valuable in determining treatment and indicating prognosis.

DISCUSSION *by F. F. Gundrum, Sacramento; William J. Kerr, San Francisco; A. W. Hewlett, San Francisco; Harry Spiro, San Francisco; F. R. Nuzum, Santa Barbara.*

THE diversity of opinion regarding the variation in heart size, which accompanies changes in compensation, has largely resulted from statements based on inexact data. We have attempted in this paper to so correlate clinical observations and laboratory findings that a clear vision of the subject may be attained. For some time we have felt convinced that the heart area does alter with changes in cardiac function. With this in view, we have selected twenty cases of enlarged hearts, without reference to their outcome, and demanding only that sufficient study had been made upon them to show what, if any, change had taken place during the course of disease. The minimum time of observation of these cases was two months. The maximum was five years and five months. The average period of observation was one year and five months.

Of these twenty cases, eleven showed clinical signs of decompensation at some time during observation. The remaining nine cases showed evidence of lowered cardiac reserve, but no symptoms of decompensation. We here determine decompensation by the clinical signs of venous stasis. In those cases classified under the heading of lowered cardiac reserve, anginal pain and shortness of breath on exertion were the most frequent symptoms.

The cardiac areas were computed from orthodiagrams after the method of Van Zwaluwenburg. Here the formula for computing the area of an ellipse was utilized; namely, the product of the long diameter drawn through the center of the figure and the short diameter erected perpendicular thereto at the widest portion multiplied by the factor 0.7854. Van Zwaluwenburg demonstrated the accuracy of this method by a comparison of areas determined by this method and by planimeter readings. More recently, Karshner and Kennicott, after a study of one hundred normal and abnormal cases, showed an average variation of 2.6 per cent between areas determined by planimeter readings and those figured on a basis of the formula of Van Zwaluwenburg.

Using this very accurate method of measurement of heart areas as a standard, we have demonstrated in seven of the eleven cases of cardiac decompensation a definite decrease in area accompanying reestablishment of compensation. Two of these eleven cases showed progressive increase in size as the hearts gradually failed. One heart showed no change with clinical improvement, and one increased in area.

Of the nine cases of lowered cardiac reserve with cardiac enlargement, five showed decreased heart areas upon clinical improvement; three remained unchanged; while the one remaining heart increased in area as cardiac reserve improved.

In fourteen of the twenty cases, a change in heart area was demonstrated, while four remained unchanged and two increased in size with clinical improvement.

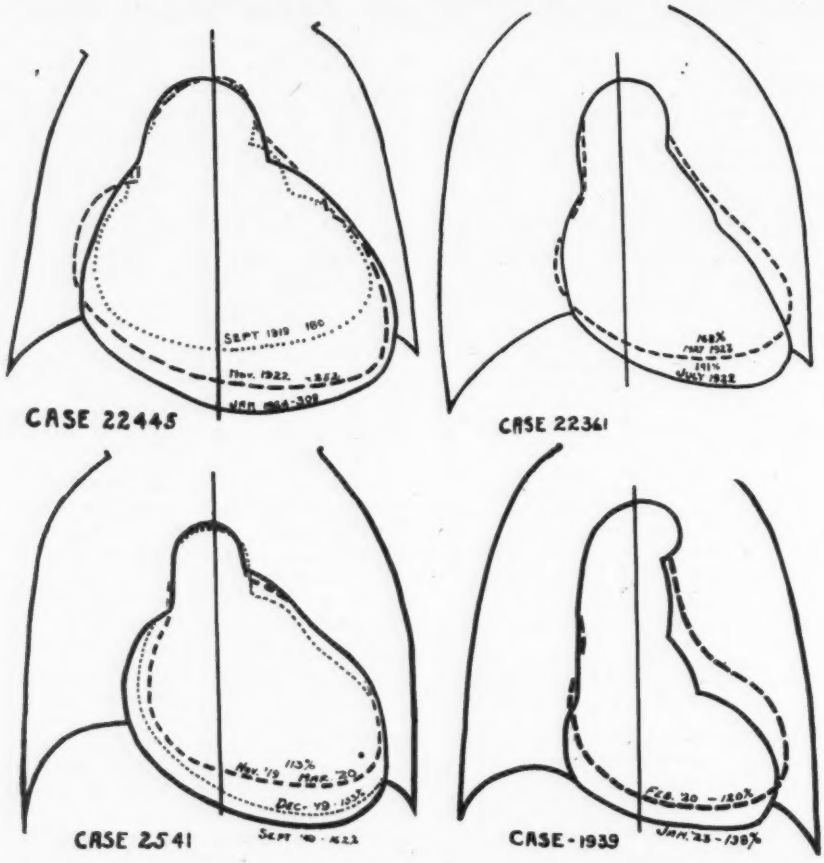
In the entire series, four cases at some time showed increase in heart areas accompanying clinical improvement. These probably demonstrate the result of muscular hypertrophy. The improved tone of the heart is readily observed during fluoroscopic study. The complete orthodiagrametric report in such cases throws more light on the reason for the increased size than a simple statement of area in percentage would indicate. Even among those cases of cardiac decompensation where a definite decrease in cardiac size has followed compensation, there are a few cases which have shown a progressive increase in size upon a resumption of activity following treatment with rest. The area in these cases never reaches the height reached during the period of decompensation, and the tone of the muscle observed during examination shows progressive improvement.

The accompanying chart shows in detail, under the date of examination, the diagnosis, etiology, electrocardiographic and polygraphic diagnosis, orthodiagrametric findings, and clinical observations in the twenty cases studied.

The diameters M. R. and M. L. and total diameters are included, since they are the ones commonly employed by the clinician in his study of the heart. These measurements give information of comparative value, but fall far short of measurements of cardiac area as a means of studying changes in the size of the heart.

The first diagram represents the orthodiagramatic findings of a normal heart. In computing cardiac areas, the long diameter A. B. (in centimeters) is multiplied by the short diameter C. D. (in centimeters), and the product thus obtained is divided by the normal obtained in a similar manner based on body weight. The perpendicular line represents the anatomical center of the body. The M. R. and M. L. are raised perpendicular to this central line at the point of greatest cardiac width to the right and left.

The diagrams were prepared by making a composite picture of the actual orthodiagrams. They demonstrate the changes in the cardiac silhouette



during the course of disease. The areas computed as described above are recorded at the base of the outline in each case.

Case No. 2541—This patient was a housewife of 50. She reported September 29, 1919, complaining of dyspnoea and orthopnoea of two weeks' duration. With the exception of repeated attacks of tonsillitis and typhoid fever at the age of 34, the patient had been in good health until February of 1918, when she noted a sudden irregularity of her heart. Physical examination revealed a mitral insufficiency and stenosis with an auricular fibrillation. Her orthodiagram at this time (September, 1919) showed an area of 162 per cent, and is represented by the outer solid line in the diagram. By November 17, 1919, the patient had improved; her pulse, still irregular, was slowed and no longer showed a deficit. Her total transverse diameter was reduced 2.5 cm., and her cardiac area reduced 49 per cent (represented by the heavy, broken line). On December 23, 1919, the patient again reported, showing signs of decompensation; her cardiac area had increased to 133 per cent, shown by the small, broken line on the slide. By March 29, 1920, the patient was greatly improved, her heart had receded to its previous area of 116 per cent, which is virtually that of November of 1919, and shown as the heavy, broken line.

Case No. 1939 is one of a physician of 58. The diagnosis was luetic aortitis, cardiac dilatation and hypertrophy, chronic nephritis with hypertension, and chronic myocarditis. He presented a right bundle branch block. He had repeated attacks of pulmonary oedema, finally dying in one in January, 1924. He was first seen in March, 1917. He gave a history of having had two attacks of acute oedema of the lungs in January and March. He was complaining of dyspnoea on exertion. He had a blood pressure of 210 systolic and 165 diastolic. His blood Wassermann was three plus. After being on anti-luetic treatment, he reported much improved on June 26, 1917. His first orthodiagram made in February, 1920, gave an area of 120 per cent (represented by the inner broken line), and his fluoroscopic examination revealed a uniformly broad aortic shadow 6 cm. wide. He was feeling well, and working at this time. His antiluetic treatment was continued. January, 1922, patient reported at office. He was definitely failing in health. His electrocardiograms showed ventricular extrasystole with right bundle branch block. His cardiac area had increased to 138 per cent (represented by the outer solid line), an increase of 18 per cent. In December, 1922, he had a severe attack of hemorrhagic oedema of the lungs. The patient grew progressively worse and died in January, 1924, with acute hemorrhagic oedema of the lungs.

Case No. 22,445—A nurse, aged 51, came to the office in August of 1919, complaining of "heart trouble." Her previous illnesses were scarlet fever, tonsillitis, typhoid fever, malaria, and rheumatism. A diagnosis was made of mitral and aortic insufficiency, chronic myocarditis, and auricular fibrillation. In September of that year her heart was compensated. Her cardiac area was 180 per cent (inner dotted line). She was on duty as a nurse. In September, 1922, she was suffering from decompensation, with ascites, oedema of legs, cyanosis, and enlarged liver. Her cardiac area was 252 per cent of the normal (the broad, broken line). The patient was improved by February, 1923, but never regained her compensation. Hers was a history of steady decline. When last seen, in January of 1924, she was able to get about a little, but was greatly restricted as compared with her former activities. Her cardiac area was 309 per cent, and is shown in the diagram by the solid line.

Case No. 22,361—A man of 42, first seen in July, 1919, complaining of cough, dyspnoea (nocturnal, and on exertion), and precordial pain. He had a decompensated heart, with mitral regurgitation and chronic myocarditis. His cardiac area was 191 per cent. In October, 1922, after

No.	Age	Diagnosis	Etiology	Dates	E. K. G. and Polygraphs	Heart Measurements M. R.	M. L.	Total	Area	Condition	Remarks
2541	50	Mitral disease. Cerebral embolism.	Tonsillitis. Typhoid fever.	Sept. 29, 1919	.....	5.6	9.9	15.5	162%	Decompensation.	Dyspnoea. Orthopnea. Radial pulse 80; apex 96; deficit 16.
				Nov. 17, 1919	.....	3.8	9.9	13.7	116%	Improved.	Pulse 72, no deficit. Patient improved.
				Dec. 23, 1919	.....	4.6	10.1	14.7	133%	Signs of decompensation.	Distress after eating.
				Mar. 29, 1920	.....	5.0	9.0	14.0	116%	Improved.	
				May 14, 1920	.....	5.0	9.0	14.0	116%	Improved.	Patient able to shop.
				Nov. 23, 1920	.....	5.0	9.0	14.0	116%	Improved.	Free from cardiac symptoms.
				May 25, 1922	.....	.....	.....	.....	.....	Death.	Cerebral embolism.
1939	58	Luetic aortitis. Cardiac dilatation and hypertrophy. Oedema lungs. Hypertension. Right branch block. Chronic nephritis. Myocarditis, chronic.	Syphilis.	Feb. 27, 1920	.....	4.8	8.8	13.6	120%	.....	Wassermann ++++.
				Mar. 21, 1920	.....	.....	.....	.....	.....	.....	Reports 3 attacks oedema of lungs.
				Jan. 19, 1922	Left ventricular extra systole. Right branch block. Notched Q R S in Leads I, II and III.	4.1	9.4	13.5	138%	Failing.	Wassermann ++++. Mercury and K. I.
				Dec. 13, 1922	.....	.....	.....	.....	.....	.....	Severe attack hemorrhagic oedema of lungs.
				Jan. —, 1924	.....	.....	.....	.....	.....	Death.	Pulmonary oedema.
21362	42	Myocarditis, chronic. Heart block.	Tonsillitis.	July 20, 1921	Heart block 2 to 1.	4.2	11.5	15.7	167%	Decompensated.	Fatigue and pain in chest after exercise.
				Sept. 6, 1921	Heart block 2 to 1.	5.2	9.5	14.7	150%	Improved.	Walking 15 blocks and climbing stairs without distress. On salvarsan.
				Oct. 26, 1921	.....	.....	.....	13.6	114%	Improved.	Course of mercury succinamide.
				Dec. 16, 1921	.....	.....	.....	15.7	119%	Condition good.	
1285	62	Tonsillitis, chronic. Mitral stenosis. Auricular fibrillation.	Influenza. Tonsillitis, chronic.	Sept. 5, 1918	Auricular fibrillation. Inverted T in Lead II.						
				Nov. 25, 1919	.....	3.7	7.4	11.1	94%	.....	Precordial pain with shortness of breath on exertion.
				Nov. 20, 1923	Auricular fibrillation (fine). Slight right axis deviation.						
				Feb. 19, 1924	.....	4.5	8.5	13.0	120%	Exceptionally well.	Back at work.
22267	59	Angina pectoris. Arteriosclerosis. Abscess alveolaris. Pericarditis, acute. Pleurisy.	Arthritis, 8-10. Alveolaris abscess.	June 27, 1922	.....	5.1	11.7	16.8	151%	Acutely ill.	Pleurisy with pericarditis with acute anginal attack. Four abscessed teeth.
				Aug. 26, 1922	.....	.....	.....	.....	.....	.....	Abscessed teeth removed.
				Nov. 10, 1922	.....	4.6	10.4	15.0	135%	Much improved.	
				Dec. 1, 1922	Notching Q R S L. II. Left ventricular preponderance. Inverted T Lead I T opposite to main deflection in Leads I and III.						
				Feb. 8, 1923	.....	5.0	11.2	16.2	141%	Improved.	
				Dec. 16, 1923	.....	.....	.....	.....	.....	Improved.	Walking one mile a day. Enjoying his work.
2801	31	Mitral stenosis et insufficiency. Alveolar abscess. Paroxysmal tachycardia.	Influenza, 30. Alveolar abscess.	May 13, 1920	.....	4.8	10.5	15.3	194%	Compensated.	No symptoms. Was told she had heart trouble.
				Jan. 27, 1921	Polygraph-paroxysmal tachycardia, rate 190, regular.	4.8	10.5	15.3	244%	Decompensated.	Dullness in both flanks. Attack of tachycardia.
				Dec. 23, 1921	.....	4.8	9.0	13.3	187%	Improved.	Walking short distances.
819 S	50	Endocarditis, chronic. Auricular fibrillation.	Arthritis, age 15.	Jan. 2, 1920	.....	.....	.....	.....	.....	Decompensation.	Orthopnea. Dyspnoea. Rales in both bases.
				Feb. 4, 1920	.....	4.6	9.8	14.4	172%	Improved.	

No.	Age	Diagnosis	Etiology	Dates	E. K. G. and Polygraphs	Heart Measurements M. R.	M. L.	Total	Area	Condition	Remarks
				Feb. 18, 1920		4.2	9.3	13.5	138%	Continued improvement.	Lungs clear.
				Oct. 6, 1920		4.5	9.9	14.4	147%	Moderate decompensation.	Slight nocturnal dyspnoea. Blood pressure gradually declining. 96/80.
				Oct. 19, 1920		4.6	9.1	13.7	135%	Improved.	
				Feb. 9, 1921		4.6	10.3	14.9	183%	Decompensation.	Acute bronchitis in January. Heart absolutely irregular. Rales in both bases.
				May 25, 1921		5.5	10.1	15.6	168%	Improved.	
				Sept. 3, 1921		.....	.....	.....	.....	Decompensated.	Failing rapidly.
				Sept. 27, 1921		.....	.....	.....	.....	Death.	
22445	51	Mitral and aortic insufficiency. Myocarditis. Auricular fibrillation.	Tonsillitis. Rheumatism.	Sept. —, 1919		7.5	10.0	17.5	180%	Compensatory.	Working as nurse.
				Sept. —, 1922		8.8	10.6	19.4	252%	Decompensated.	Ascites. Oedema of lungs. Dyspnoea, cyanosis and enlarged liver.
				Feb. 9, 1923	Auricular fibrillation. Right ventricular preponderance. Rate 69. Inverted T in Leads III. Notching of Q R S in all Leads.	.....	.....	.....	.....	Improved.	Liver enlarged. Fluid in flanks.
				Dec. 15, 1823	Auricular fibrillation. Right ventricular preponderance. Rate 54. Notching Q R S all Leads. Right ventricular extra systole. Diminutive deflection.	.....	.....	.....	.....	Gradually failing.	In hospital with acute respiratory infection.
				Jan. 23, 1924		8.3	11.2	19.5	309%	Failing.	Doing very little.
22153	70	Myocarditis. Ventricular extra systole. Paroxysmal auricular fibrillation.	Influenza. Tonsillitis. Arthritis. Typhoid, 35.	Mar. 25, 1922	Polygraph—rate 103. Ventricular extra systole with alternation following.	2.8	10.0	12.8	160%	Mild decompensation.	Palpitation. Dyspnoea on exertion, and weakness.
				Dec. 8, 1922	E. K. G. Ventricular extra systole right and left. Inverted T in Lead III.						
				Jan. 4, 1923		2.8	10.0	12.8	160%	Improved.	
2919	45	Mitral stenosis. Regurgitation. Tonsillitis, chronic.	Tonsillitis.	Aug. 26, 1920		4.0	10.2	14.2	194%	.....	Shortness of breath. Precordial pain and palpitation on exertion.
				Sept. 20, 1920		.....	.....	.....	.....	.....	Tonsillectomy.
				June 20, 1921		4.7	10.5	15.2	194%	No improvement.	Marked shortness of breath on exertion.
				May —, 1923		.....	.....	.....	.....	.....	Cardiac—death.
3037	34	Myocarditis. Auricular extra systole.	Typhoid fever, age 24. Hyperthyroidism, age 18.	Dec. 23, 1920	Polygraph—alternate auricular extra systole.	3.0	7.5	10.5	124%	Moderate decompensation.	Rapid irregular heart. Precordial pain. Slight dyspnoea.
				Aug. 15, 1921		4.5	7.0	11.5	144%	Improved.	Heart slower. Better compensation. Walking 1½ miles.
				Mar. —, 1924		.....	.....	.....	.....	.....	General health best for 10 years.
2667	54	Mitral insufficiency. Auricular fibrillation.	Tonsillitis, chronic. Broncho-pneumonia, 54. Typhoid, 14. Myositis, chr.	Jan. 21, 1920		4.2	11.0	15.2	130%	Compensatory.	General debility following pneumonia.
				Nov. 10, 1921		4.0	10.2	14.2	113%	Improved.	
2446	52	Toxic hyperplastic goitre. Myocarditis. Nephritis, chronic.	Chorea, 13. Tonsillitis. Goitre, 40.	Sept. 23, 1919		.....	.....	.....	.....	.....	Partial thyroidectomy.
				Feb. 10, 1920		2.0	9.4	11.4	125%	Improved.	Doing a little work. Heart rapid.

No.	Age	Diagnosis	Etiology	Dates	E. K. G. and Polygraphs	Heart Measurements M. R.	M. L.	Total	Area	Condition	Remarks
				Mar. 4, 1921		2.0	9.4	11.4	125%	No improvement.	No loss of compensation. Tremor. Sweating. Diarrhoea. Heart 142 per minute at times.
21080	48	Mitral stenosis et insufficiency. Auricular fibrillation.	Tonsillitis. Alveolar abscess. Pyorrhoea. Colecystitis and colelithiasis.	Feb. 8, 1921		6.5	12.3	18.8	286%	Decompensated.	Dyspnoea on exertion. Orthopnea. Liver 10 cm. below costal border. Oedema of legs to thighs.
				Apr. 15, 1921		5.7	11.7	17.4	210%	Improved.	Slight pretibial oedema. Liver smaller, still palpable.
21085	36	Chronic nephritis with N and NaCl retention. Myocarditis, chronic. Hypertension.	Influenza, 33. Antrum, 24. Nephritis, 36.	Sept. 2, 1921		4.7	11.1	15.8	184%	Decompensated.	Precordial distress on climbing hills. Slight oedema. Dyspnoea.
				Nov. 4, 1921		4.1	10.7	14.8	170%	Improved.	
				——, 1922		.....	.....	.....	.....	.....	Death—nephritis.
22103	42	Myocarditis, chronic. Mitral insufficiency. Partial heart block.	Influenza, 39. Otitis media, 42. Tonsillitis, chr. Infantile paralysis, 3.	Feb. 27, 1922		2.7	10.2	12.9	151%	Weak following otitis media.	Slow, irregular pulse. Hypertension. No cardiac symptoms.
				May 5, 1922	Delayed conduction time. Partial heart block. Notching Q R S Lead III.	2.2	10.2	12.4	139%	Improved.	Patient free from symptoms.
23211	55	Myocarditis, chronic. Angina pectoris.	Influenza, 55.	Feb. 19, 1923		3.2	10.5	13.7	118%	Compensated.	Tracing made in France.
				Apr. 26, 1923		2.6	11.2	13.8	118%	Improved.	Compensation good. Tracings made here on return from abroad.
21151	72	Nephritis, chronic. Myocarditis, chronic. General arteriosclerosis. Herpes zoster.	Tbc. at 12.	Mar. 16, 1921		5.4	13.0	18.4	201%	Decompensated.	Ten days previous had sudden brief loss of consciousness, preceded by dizziness and dyspnoea. Liver enlarged.
				Apr. 26, 1921		4.9	11.9	16.8	175%	Improved.	Urea dropped from 26 to 20.
				June 30, 1921		5.9	12.3	18.2	194%	Good.	Cardiac reserve good. Liver palpable.
22410 S	39	Hyperthyroidism. Myocarditis. Tonsillitis, chronic.	Tonsillitis. Hyperthyroidism.	Aug. 22, 1922		3.9	9.2	13.1	127%	.....	Basal metabolism +44%. Rapid pulse 100-120. Loss of weight. Shortness of breath.
				Sept. 26, 1922		.....	.....	.....	.....	.....	Tonsillectomy.
				Oct. 22, 1922		.....	.....	.....	.....	.....	Thyroidectomy. Basal metabolism +11%.
				Oct. 24, 1922		3.7	9.3	13.0	121%	Improved.	
				Nov. 21, 1922		.....	.....	.....	.....	.....	Basal metabolism +.5%. 4/5 thyroid removed.
				Feb. 16, 1923		4.5	8.7	13.2	111%	Much improved.	
22361	42	Myocarditis. Mitral regurgitation.	Arthritis, 11. Influenza, 39.	July 17, 1919		4.2	11.0	15.2	191%	.....	Cough, dyspnoea (nocturnal and on exertion). Precordial pain.
				Oct. 9, 1922		4.6	11.0	15.6	165%	Improved.	Free from dyspnoea. No precordial pain.
				Feb. 2, 1923	Left ventricular extra systole. Notching of Q R S in Lead III.	.....	.....	.....	.....	Improved.	Limited activity. Four hours' work in office.
				May 16, 1923		4.6	11.0	15.6	168%	Improved.	Shape of heart improved.
				Feb. 1, 1924		5.0	11.3	16.3	185%	Improved.	Free from signs of decompensation. Slight dyspnoea on exertion. 12 hours' activity. 2 hours' rest in bed.

treatment, the patient was free from symptoms and presented a cardiac area of 165 per cent. Improvement continued and the patient was allowed limited activity and four hours' work at his office daily. His electrocardiograms were negative but for ventricular extrasystoles. In May, 1923, his heart was slightly larger (168 per cent), but of definitely better tone. This heart outline is represented by the broken line in the illustration. When last seen in February, 1924, the patient was free from signs of decompensation. He had slight dyspnoea on exertion. He was active about twelve hours a day, with two hours' rest in the afternoon. His heart was definitely larger than at the previous examination (185 per cent), but his muscle tone was good.

CONCLUSIONS

1. That cardiac areas, as computed in the orthodiagram, show a fluctuation during compensation and decompensation.
2. That in cases of lowered cardiac reserve enlarged hearts are seen to decrease in size with clinical improvement.
3. That in a small number of cases subsequent enlargement of cardiac area accompanying clinical improvement and resumption of exercise would point to cardiac hypertrophy.
4. That correlation of cardiac areas and clinical findings give information valuable in determining treatment and indicating prognosis.

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DISCUSSION

F. F. GUNDRUM, M. D. (Capital National Bank Building, Sacramento)—I have been very pleased with this paper. The publication of such accurate, painstaking, and continuous study of heart size will throw a very needed light upon our hitherto somewhat hazy concepts of the relation of cardiac dimensions to cardiac ability. We have long been taught that heart weakness was associated with dilatation, and I believe it was Osler who said that endurance was to be measured by the ability of the heart to resist this constant tendency to dilate. With more accurate study, as appears in Dr. Frick's paper and elsewhere, it begins to seem evident that this idea will have to be somewhat revised, and endurance may prove to be, in large measure, a function of blood-sugar. Although we are all daily seeing examples of the reduction in the width of cardiac dullness which accompanies the recovery from heart failure, increase in the ability of the heart to do work is not always associated with a decrease in heart size. It is hardly necessary to use such elaborate technique to make a clinical diagnosis of heart failure, and to get a quite accurate picture of the general outline of the heart. However, this sort of research will prove invaluable in giving us the exact relations between those very small differences in heart size and shape (if there are any) which are associated with the minor degrees of heart insufficiency, and perhaps foretell a cardiac breakdown.

WILLIAM J. KERR, M. D. (University Hospital, San Francisco)—The report by Drs. Frick, Kennicott, and Karshner is of interest to physicians in general and to cardiologists in particular, because it emphasizes the value of accurate methods of determining cardiac measurements. We cannot rely on our present methods of physical examination for the accurate sizes of hearts, particularly in those cases where emphysema is a complication or in individuals who have an unusual amount of subcutaneous fat. Here the orthodiagraphic method comes into use.

The authors have shown the variation in cardiac area over a long period of time in their series of cases, and their charts definitely show that the variations are usually associated with changes in the cardiovascular status of the patient. The value of this method in treatment and in prognosis seems to me to be very great and should be more generally employed. One should be extremely careful, I think, to have the orthodiagrams taken of the patient in the same position each time so that changes in shape and position of the heart by changes and position in the patient will be obviated or minimized.

I feel that the study of the heart with the area of the orthodiagraphic shadow and the orthodiagrapic plate before us for changes in contour give a very good idea of the conditions present, and is much more satisfactory than either method alone. These methods do not replace the other methods of physical diagnosis and examination of the patient, but are useful aids in the proper treatment and prognosis of the case.

A. W. HEWLETT, M. D. (Stanford University Medical School, San Francisco)—This paper demonstrates the value of accurately measuring the size of the heart shadow by means of the x-ray. The difficulty encountered in making accurate measurements of the heart shadows in different patients arises from the considerable variations encountered in normal persons. On account of these variations, the heart shadow must be considerably larger than the average before we are certain that it exceeds the upper limit of normal. In the present paper, comparative observations were made on the same individuals at different times, so that small changes in area are significant. These comparative measurements show clearly that, in certain patients, the heart shadow lessens as compensation improves. From my own experience with chest plates of cardiac patients, I can confirm the observation that certain patients show a decrease in the heart shadow coincident with clinical improvement, while others show little or no change. The authors report four cases in which, at some time, the heart shadow became larger during clinical improvement. They attribute this to cardiac hypertrophy. It appears to me improbable that a marked change, such as that observed in Case 1285, could be due entirely to thickening of the heart muscle. Increase of the heart shadow, especially in diastole, may be caused by a slower heart rate. It is also probable that, in some instances, hypertrophy goes hand in hand with a moderate dilatation even when compensation is improving.

HARRY SPIRO, M. D. (Flood Building, San Francisco)—The orthodiagraphic method of cardiac examination has had a hard path to travel. Popular prejudice decided that the method was too tedious, required extraordinary skill and high-priced and complicated apparatus; therefore, it has not been more in demand. But no sooner does an individual decide upon a careful and thorough study of cardiac conditions than he realizes that, for dependable work, orthodiagrams are an indispensable supplement to the radiograms.

Today the orthodiagraphic apparatus is very simple and does not demand more than ordinary skill to operate and interpret. Its value is tremendous, particularly as an aid in diagnosing borderline cases of cardiac defects. The authors have shown further that it may be a factor in preventing a cardiac breakdown because one can recognize changes in size and shape of the heart which often precede cardinal symptoms of severe cardiac distress.

While in general I do not believe that cardiac shape is dependable in judging cardiac muscle tone, still there are cardiac types which are reliably associated with certain cardiac defects. For instance, if an orthodiagraphic study has shown a certain type heart, and after a period of time investigation shows a distinct deviation from the type previously found, one could reasonably assume that the heart was not standing up to its work properly, and the treatment should be changed accordingly.

We have always believed that progressive increase in cardiac size spelled approaching trouble. On the contrary, the authors have called attention to the possibility that if a decompensated heart improves and decreases in size, and subsequently as the improvement continues, the heart is shown by careful measurements to be increased in size; then this latter increase in size is due to healthy changes and need not be feared. The proof of the above is definitely a step forward, and shows with what thoughtful judgment the authors performed their work and illustrates forcibly the great value of orthodiagraphic study.

Drs. Frick, Kennicott, and Karshner are to be congratulated in their work of blasting another stone from the path of orthodiagraphy and scoring another point for the long neglected, but faithful, hard-working heart.

FRANKLIN R. NUZUM, M. D. (Cottage Hospital, Santa Barbara)—This paper demonstrates in a very convincing manner the aid that is available by the use of accurate methods of determining the size and shape of the heart. The point has been established that the size and shape of the heart varies in the period of time that elapses between broken compensation and compensation, and that a knowl-

edge of this change is of value in diagnosis, prognosis, and treatment.

Quite aside from the object of this paper, the change of the size of the heart as a result of disease, are some observations made recently in Boston upon the change in the size of the heart in trained athletes following severe exertion. The same methods of determining heart measurements were used, and the information gained is very interesting. Heart measurements were made of these athletes before, immediately after and some days after the completion of a 25-mile marathon race. This race, being an annual event, attracts the best distance runners in the country and men who are thoroughly trained for the event. In brief, the width of these hearts decreased an average of 2 cm., as shown by measurements at the conclusion of the race. Within two to five days these hearts had again returned to the size as demonstrated before the race. This is not in harmony with what many believed would happen as the result of a severe strain such as this race must be. It demonstrates again the value of accurate methods in establishing facts.

The Clinical Teacher and the Medical Curriculum —Harvey Cushing, Boston (Journal A. M. A.), says there are fashions in teaching, like fashions in other things, and one must conform or be regarded as out of date, even though, after all, we may reach our destination whether we ride side-saddle or ride astride. Just now, for example, in our medical schools the "didactic lecture" is taboo. Who first put the taboo on lecturing was probably someone in authority incapable of holding the attention of a group of students by this method. Individuality is now submerged: our teaching, must—to use a greatly abused word—be standardized, as though our schools were factories. The personal influence of the teacher has largely become swamped, and we try vainly to atone for this by juggling with the curriculum, forgetful that no two instructors in any two schools can possibly reach students with precisely the same methods; and that no two students get their inspiration, such as it is, in the same way out of their particular school or its individual instructors. I presume the Harvard Medical School is no different from most medical schools, in that no faculty member is quite satisfied with the existing curriculum and, as a result, about every three years some one protests with sufficient energy to force on his reluctant colleagues some radical changes. Students can be well grounded through the medium of any course. In any old and established school, the curriculum inevitably becomes hidebound. Meanwhile, we have become fairly well accustomed to the view that subjects beginning with the study of morphology and ending with the clinical specialties must be taught in a given sequence. So far as the curriculum is concerned, our discussions in faculty meeting are given over largely to the struggle for elbow-room between established courses, of which there are too many. We have just been going through one of our triennial turn-overs at the Harvard Medical School, in the endeavor to find out what is wrong with the student and with our method of teaching. This time, pressure has been brought to bear by certain members of the faculty of a philosophical turn of mind, who have discovered that the trouble with the undergraduate is that he has no time for intellectual cogitation. Consequently, at the risk of not meeting our obligations to state board requirements, we have materially cut down our hours of instruction so that the students have their freedom Tuesday afternoon and Thursday afternoon and all day Saturday and Sunday. We have as yet made no statistical study of the amount of rumination they do in these free hours; nor do I think such a study will ever be made, because by the time there are sufficient data to rely on we shall probably have gone back to the old system, or new courses will have crept in to fill up these free afternoons.

EDITORIALS

RULES AND FEE SCHEDULE OF DISTRICT OF COLUMBIA MEDICAL ASSOCIATION PLEASE ORGANIZED LABOR

The reaction produced by the new published rules and fee schedule of the District of Columbia Medical Association still reverberates through the daily and periodic press of the country. Many editors constantly criticize the action, while others, and particularly that part of the press identified with organized labor, are pleased at the action taken. The majority of commentators profess to see in the action a "tightening up" of physicians' organizations and the introduction of "business ethics" into their methods and conduct. Some editors castigate the doctors for introducing the "lockout" and a scale of wages and working conditions similar to those of labor unions. Editors of papers sympathetic to labor unions welcome these innovations and predict affiliation of medical associations with the American Federation of Labor as the logical end to this movement.

Fee Schedule—The fee schedule is too long to reproduce. Fees vary from $3 to $5000 and upwards. The rules relating to fees are interesting. They are:

1. The following fees shall be charged for professional services, subject, however, to the several rules which are appended: . . .

2. The foregoing table contains the standard fees which *shall be demanded;* they shall be *increased* according to the judgment of the practitioner concerned, in all cases of extraordinary detention or attendance; also in proportion to the importance of the case, of the responsibility attached to it, and to the service rendered when these are extraordinary. They shall be *diminished* at the discretion of the physician when he believes that the patient cannot afford to pay the regular fees, and yet is able to make some compensation; but diminishing the fees except for motives of charity and benevolence is a violation of this regulation.

3. Medical officers connected with the staffs of the hospitals and dispensaries in the District of Columbia shall charge the usual fees for medical services rendered to persons who seek gratuitous services when they are able to pay.

4. Clergymen are not entitled to gratuitous services except when they are in indigent circumstances. Graduates of medicine are not entitled to gratuitous services unless they devote their entire time to the practice of medicine or by reason of age or infirmity have retired from the regular practice of medicine, or unless such graduates of medicine are in indigent circumstances.

5. It is not designed by these regulations to prevent gratuitous services to those who are incapable of making remuneration without distressing themselves or their families.

6. When a physician engaged to attend a case of obstetrics is absent and a second attends the patient, the latter may charge the full fee, but shall relinquish the patient to the first on his return; and in no case shall the second continue to attend except to render indispensable service during the continued absence or disability of the first.

7. When one or more physicians are called in consultation the attending and consulting physician or physicians shall charge at least the ordinary fee for delivery or other services; but when the latter are not detained in attendance they shall only charge the usual fee for consultation.

8. It is recommended that the members of this society

present their accounts for professional services at the close of the attendance; and it shall be the duty of each member to obtain, if possible, a monthly settlement from all his patients.'

9. No member of this society shall make a contract, expressed or implied, to attend an individual, family, club, lodge, or other organization by the year, or on any terms other than those authorized by these regulations.

Rule 9 apparently would prevent membership of any salaried doctor, regardless of the size of the salary or the nature of his work.

OTHER RULES

In addition to those affecting fees, there are other interesting rules, from which we quote:

2. In certificates of illness concerning absence from official duties given to employes in the public service, or others, the disease shall not be specified, neither shall the name or nature of the disease be divulged by any written description or statement of symptoms, given to the patient, nor by any specification of the disorder, nor by any disclosure which may be construed as an evasion of the purpose of this regulation.

3. It shall be the duty of members of this society to discourage patients from defrauding other members, and it is expected that the members will use all just and proper means to assist one another in the collection of their fees for professional services.

4. No member of this society who has been called in as consulting physician, in a medical or surgical case, shall assume sole charge of the patient, during the same illness, unless he shall have been specifically requested to do so by the attending physician.

5. No member of this society shall offer, solicit, give, or receive any commission for recommending or referring patients for general or special treatment, diagnosis or operation; or shall solicit or accept any commission from any pharmacist or other dealer in supplies and appliances for the sick and injured on account of patients referred to them.

1. Every institution for medical charity shall require from every applicant for relief in its hospital or dispensary a written certificate, to be obtained as hereinafter provided, that said applicant is unable to pay. Emergency cases are to be excepted from the operation of this rule.

3. Members of this society shall be entitled to the privilege of attending private patients occupying private rooms in any of the public hospitals of this city.

4. The members of the medical staffs of hospitals, when attending medical or surgical cases in private pay rooms, shall insist upon proper payment for their services, except in the case of patients who are unable to pay.

5. Whenever the medical staff of a hospital or dispensary, or any member thereof, is forced to resign, and when, after due hearing, this society finds that the resignations were for unjust and insufficient cause, it shall be forbidden to any member of this society to accept a position on the staff of said hospital or dispensary.

This presumably is the rule referred to by some as the "lockout rule."

6. Whenever one or more members of the medical staff of a hospital or dispensary are dismissed, and when, after due investigation, this society finds that such dismissal was without just and sufficient cause, it shall be forbidden to any member of this society to fill the vacancy created thereby.

9. No member of the staff of any hospital, receiving patients in private rooms, shall attend such private patient sent to the hospital by a member of the society not a member of the staff, unless specifically requested to do so by the attending physician.

It is not our purpose to comment upon the action of the Washington physicians, but rather to review the parts of their action that have led to so much controversy.

GROUP MEDICINE UNDER A NEW NAME

Under the new and particularly inappropriate name of "Guidance Clinics," group medicine has again come to the fore: by group medicine, meaning grouped service by one or as many physicians and other persons as are necessary to make complete and inclusive diagnoses and render any and all indicated services to any individual person.

In the beginning, the old-time family physician was the "group," the "health center," the "child guidance" clinic. He included in his sphere all of the best knowledge then available in the supervision, advice and care he gave to his clients. Most of them still continue to render to the best of their ability all the broad services that some appear to believe to be newly discovered by them. They have guided, and are now guiding, some pretty fine specimens of children to manhood, and then they keep on guiding them until death calls.

Then knowledge increased and became more complex, and medicine, in the broad sense of that term, also became more difficult and complex. Most doctors tried to keep up with and utilize the best of that knowledge in the "guidance" of their clients. Most of them still do so.

Medical schools tried to sort theory from facts and add what was worth while to the instruction given to crop after crop of younger physicians produced annually. They still do precisely this up to a certain level of attainment, and above that level both education and practice have split the field into several essential specialties. Also some that probably are unessential. Practice and education have both then tried to co-ordinate these specialties so as to bring them to bear upon the individual in diagnosis, treatment and "guidance." Many schemes for doing this have been promoted, including clinics, health centers, partnerships, groups and others, and now we have the latest, the "Child Guidance Clinic." Tomorrow it will be some other name.

Yesteryear Doctor A practiced medicine, including "guidance" for child and adult. Last week Doctors A, B, and C formed a partnership to expand their service. Yesterday Doctors A, B, C, D, E, plus pathologist, psychologist, nurse, social worker, and others formed "groups" and corporations to do this work. Today Doctors A, B, C, etc., form a clinic, a health center, a service station, a life-prolonging clinic, a "guidance clinic," or some other form of wholesaling health service "free." Tomorrow the popular name will again change to the latest fad in nomenclature; but you will notice that all through the past, today and tomorrow, the service-givers are the same people. Will they do better work under one name than another?

On page 164, this issue, is a well-told advocacy of "Child Guidance Clinics" by Doctor R. L. Richards. It is a clear and worthwhile presentation of an old subject under a new and unfortunate term. It is an excellent health and happiness "Bill of Rights" of citizens similar to what one will find in the writings and, to a surprising degree, in the practices of the Weir Mitchels, Oliver Wendell Holmes and Oslers of other generations. In a word, it is an excellent restatement of an ideal that intelligent and service-loving people always have been, and

are now striving for, not only in the broad field of health, but in other fields of good citizenship. If there is a single item in this "Bill of Health-rights" —so-called "guidance" service—that every worthwhile physician is not doing his best, either as Doctor A working alone or as Doctors A, B, C and others working in groups, to bring about, we would like to know what it is.

Another indication that "Child Guidance Clinic" is a slogan rather than a new movement—except in one particular to be presently noticed—is in the fact that scores of Doctors A, B, C's, who previously worked under some other designation, are now coming out under the—for the movement—popular title of "guidance clinic." There will be several of them in California within a year or so, and in a few more years they will be forgotten or the same worthy ideal will be again resloganized.

There is one feature of the much-promoted "guidance clinic" movement which seems to constitute its chief motivating force, as it does so many "new" movements in health. It is, that it must spring full-panoplied as a wholesale measure under government or some national (usually non-medical) organization control and direction. Our Doctors A, B, C must, for the time being, metamorphose themselves over night into new beings with vastly increased wisdom and powers of leadership under government or some other wealthy and not too inquisitive body. In other words, the promotion of things medical and social now follows something of the same channels used in promoting a new breakfast food or a new patent medicine. The essential feature of such promotion is salesmanship, which, if well enough managed and well enough financed, will create a desire for anything.

The paper by Doctor Rosanoff (page 167, this issue) illustrates more in detail the working of the movement for "child guidance" on a large scale. *One of the chief points in this movement is that all services to all people, regardless of their financial situation, are free of direct cost to the patient.* The very large costs connected with this service are noted by Doctor Rosanoff, as well as the *present* method of meeting these costs.

Doctor Rosanoff himself, an earnest advocate of this group method of practice, says: "The clinic procedure contains nothing that is new to mental science, except perhaps as it involves a more complete organization for the carrying out of all that we know has to be done."

LOS ANGELES AND THE PLAGUE

The prompt, scientific and effective methods employed by Los Angeles in stamping out almost at its birth a threatening epidemic of pneumonic plague is a performance highly creditable to that city, and sets an example that might well form a precedent for the guidance of other municipalities in times to come:

"No visitation," says the Arizona Republican editorially, "containing more frightful possibilities ever fell upon an American city. There was never in any plague a higher percentage of fatality, and there was never one more readily communicable. A little ignorance on the part of the authorities, a little hesitation or delay, and there would have been witnessed the most frightful devastation.

"Los Angeles is not resting on its oars since this one voyage is safely ended. Within a week it has appropriated $250,000 for a campaign against rats and squirrels; it has passed an ordinance requiring that new construction—and old construction as well—shall be rat-proof; that old buildings to which precautionary measures cannot be applied shall be destroyed.

"There are few cities and towns in America so guarded. We suppose there is no other so worshiped by the people who live in it. Los Angeles is a religion of Angelenos. We have jibed them often for their self-assertiveness and for purloining our Grand Canyon of the Colorado, but, after this, their greatest exhibition of readiness and efficiency, we forgive them all."

And so a great city, by wise and prompt action, converted what gave promise of becoming a calamity into an asset of far-reaching consequences. Although reputed to have an unusually high percentage of anti-medical citizens and to be the home of many kinds of versatile quacks, the city's action in times of serious trouble seems to show that, at most, the quackery is but a thin veneer easily brushed aside to give their educated medical agencies a free hand and generous support.

WHO PAYS THE DEFICIT?

Persons who contribute to the support of the free and part-pay work of hospitals have asked if the hospital rates paid by the State Industrial Insurance organization (state fund) were sufficient to cover the cost of the service rendered to their policyholders, and if not *who pays the deficit?*

This is a pertinent question, the answer to which may be interesting, not only to contributors to private charity, but to other citizens, and particularly to those who are served.

We know of no instance where carriers of industrial insurance operating under the provisions of the Workmen's Compensation Act of California pay hospital rates sufficient to cover the *cost* of the class of service that the injured workman is entitled to under the law.

The airing of this question in another state led promptly to an increase in the rates paid by carriers to at least the *cost of the service to the hospital.*

Additional data are being secured, and we will discuss fully several angles of this most interesting problem and some of the consequences of present practices in an early number of CALIFORNIA AND WESTERN MEDICINE.

OF INTEREST TO OUR CONTRIBUTORS

Now that the 1925 session of the California Medical Association is approaching, it seems advisable to anticipate some of the usual questions and requests made by authors about publication of their essays.

The author of a paper presented before the California Medical Association or any of its sections, *may* offer his paper for publication in CALIFORNIA AND WESTERN MEDICINE, but he is not *required* to do so as was the case prior to three years ago. Likewise, CALIFORNIA AND WESTERN MEDICINE may accept or decline any paper from any source whatsoever. Members who wish to offer their papers to CALIFORNIA AND WESTERN MEDICINE should send them to Emma W. Pope, secretary C. M. A.

and associate editor for California, or to the editor. Receipt will be promptly acknowledged, after which the essay will be carefully examined by members of the Editorial Council and either accepted or declined.

Date of Publication—Except in a few special instances, such as the announcement of new work or invited special contributions, the exact date of publication cannot be foretold. It depends upon too many governing influences, such as the date of receipt of manuscripts, the physical "make-up" of the issue, the "balancing of subjects," the proportional representation—geographical and by specialties—the amount of editorial work required, the length of the paper, and other considerations.

Helpful Suggestions — If it requires more than 3000 words to do justice to a subject, the subject is too broad for a general medical journal. If the essay exceeds 4000 words, it is not acceptable to CALIFORNIA AND WESTERN MEDICINE.

Formal stereotyped "case reports" rarely are read by anyone but the editors, and still more rarely contribute anything to the value of an essay.

Well-made photographs or well-done india ink drawings that really illustrate add value to any paper. Poorly done photographs, roentgenograms, and most "tables" definitely detract from the value of a contribution.

It is well for authors to bear in mind, as the editor is required to do, that CALIFORNIA AND WESTERN MEDICINE is a general medical journal. Probably more than 75 per cent of its readers are in general practice, and the other 25 per cent are divided between more than twenty specialties. Specialists, in preparing their articles for publication, should bear this fact in mind, and submit to CALIFORNIA AND WESTERN MEDICINE those phases of their specialty that ought to be interesting to all physicians. The more limited and more highly technical articles, written primarily for an audience made up of specialists in their subject only, should be submitted to special journals and not to a general medical journal.

Advance copies of papers to be read before the C. M. A. may be submitted at any time. This is particularly desirable for general addresses and the annual addresses of section and other officers. Priority in publication will be accorded to all officers' addresses, addresses of section chairmen and reports of the proceedings of sections, *provided these are submitted to us in good shape promptly*. Carefully prepared reports of the proceedings of sections would be a valuable contribution to medicine if the responsible officers would take the trouble to prepare them for publication.

In all cases, please save trouble, expense, and correspondence by submitting one original, clean, double-spaced typewritten copy on standard letter-size paper, and one carbon. At the same time authors will facilitate the handling of their copy if they will submit the names and addresses of physicians whom they desire to have discuss their papers.

Like all reputable medical journals, CALIFORNIA AND WESTERN MEDICINE will not publish knowingly a paper that has been submitted and accepted for publication elsewhere. CALIFORNIA AND WESTERN MEDICINE will publish papers declined by other publications, *provided* that, in the opinion of the Editorial Council, they are worthy of publication. However, papers submitted in the first instance to CALIFORNIA AND WESTERN MEDICINE will be given priority over such papers in publication.

No more certain cause of delay in publication can be invented than for an author to criticize his colleagues in his scientific discussion. This also often is the determining point in accepting or declining a paper by the Editorial Council. Those who wish to offer criticism of the profession as a whole or any section of it, should send letters to the editor. If they wish to criticize individual physicians, the letter should go to the secretary of the appropriate county medical society or to the secretary of the California Medical Association.

The paper that secured the widest and most favorable comment of our last year's issues was revised twice by the editors and three times by the author. Incidentally, the author "cussed us out" twice and wrote a fine letter of apology after reading the reviews on his article. The moral is, that an author should no more risk his scientific and cultural standing by sloppy, unedited copy than he would risk his social standing by attending a formal party dressed in overalls. Members of the Editorial Council like to examine clean, double-spaced, original typewritten copy. One of them recently told the editor that he believed that a medical essayist who would send in a smeary, much-interlined carbon copy of his article would operate with dirty fingernails. Perhaps he was joking, but it is well to remember that the only *permanent* background a doctor can create is his written and published word. This should represent the best that is in him.

LIFE INSURANCE WITHOUT MEDICAL EXAMINATION

We have been asked to discuss editorially the significance of the movement among some life insurance companies to do away with medical examinations of their policy-holders. We have no inside information, but certain reasons seem clear and certain consequences may be predicted.

Life insurance is a business; a big business carried out for financial gain and conducted under business ethics. Executives in the field will readily admit that the medical part of their work is the most troublesome and physicians' findings and conclusions the most uncertain element in the business as a business. This undoubtedly is a fact. Even under the most favorable auspices and with the best possible work by the best physicians, the results must be held up alongside careful actuarial tables before money can be assured of its earning.

With all the statistical and actuarial data that have accumulated through the years, it should be about as easy to estimate the hazards of life and thus fix a "safe" premium rate without a medical examination as it is with one. Therefore, when considered purely from an investment standpoint, it undoubtedly would be easy to fix a profitable pre-

mium rate without a medical examination. This rate would, however, perforce be a higher one.

There is another interesting speculation which might be offered. Many of the important insurance companies have developed and are rapidly developing great medical and nursing service departments of their own. By this method they can prolong the lives of their policy-holders by rendering them medical, hospital, nursing and "welfare" service, and they can thus control many situations not otherwise within their power. This substituting a policy-holder's medical service for a pre-policy medical examination suggests possible advantages to the investor. Whether or not it may prove of advantage or disadvantage to the welfare of policy-holders and physicians depends upon how it is to be handled. The possibilities are great in both directions.

There is still a third possible consequence to this movement: Groups of insurance carriers may support some great wholesale medical service that would handle all phases of medical work for their companies. Services of this class are now well established and others are in the making in several places. If wholesale medicine in some form is to come, as appears not impossible, at least for the majority of people, and consequently for the majority of physicians, the battle will be between great private organizations on one side and government on the other. Both are making definite tangible progress clear to anyone who cares to observe.

SUPPLEMENT

As is the editor's custom with editorial matter dealing with important problems of organized medicine, the above editorial was sent in proof form to twenty officers of the California Medical Association for advance comment or criticism. The questions raised by the advisors are all answered in the following reproduced from the Nation's Health, which is well worth careful perusal by all thoughtful physicians:

"The Aetna Life Insurance Company made the surprising announcement in September that thereafter on business examined within two years, additional insurance up to $10,000 would be issued without medical examination. The Travelers and Connecticut General have been setting aside one month a year during which time this privilege was available to certain limited schedules, so that the principle is not new to the insurance world but, coming as it does within a month from the concession made by the Prudential on Industrial policies in writing twenty-year endowment policies up to $2000 without medical examination, it is freely interpreted by the insurance press as indicative of a general movement toward unexamined business.

"This does not mean that the insurance to be written is to cover an unselected group, as the privilege is open only to those who have been examined within two years. The requirement of a written statement of health eliminates many bad risks, and an important factor in making the system sound is embodied in the regular health inspection feature. The object, according to Aetna officials, is not to segregate a highly superior group, but to strike the average. The Prudential limits its unexamined business to $2000 and to endowment insurance, and the additional policies may be written only by agents who have been with the company at least one year. The Aetna accepts even convertible term insurance up to $10,000.

"In commenting upon the possibilities of final universal acceptance of insurance under the non-medical plan, The National Underwriter says:

" 'The success with which British and Canadian companies have written unexamined business forecasts a favorable experience. The Sun Life of London started writing unexamined business in 1902, and has improved the status of this class until the cost of insurance is the same to them as to those who have been examined. . . .

" 'The success of group insurance in the amount of business being written without examination is advanced to show the practicability of insurance without examination. With an inspection report required and reliable agency force, there is no reason why an average group should not be obtained, in the opinion of those advocating the plan.

" 'A number of states require medical examination, and in these states neither the Aetna nor the Prudential plans can be put into effect. . . .

" 'Some states require medical examination, even in the case of group insurance, although most of them have waived the requirement on group. In one state where this requirement was made, the group companies made the examinations, but would consider the report as a group and not on individual cases, and if the group as a whole looked satisfactory, those who were undoubtedly impaired and uninsurable on individual policies were acceptable under the group.

" 'It can probably be predicted that if this practice of writing insurance without examination becomes general that the law will eventually be repealed or waived in all the states. It is probably significant that in New York and Illinois and other states that are noted for the care with which their insurance practices have been protected by law, do not require a medical examination. This seems to carry out the opinion of the critics who say there really is no excuse for the law requiring examinations and that the theory on which the law is passed is faulty.' "

A DIFFICULT SITUATION CLARIFIED

The question of the control, operation, and personnel of medical laboratories has been a burning one for some years. Upon the recommendation of a joint committee, representing the American Medical Association, the American Chemical Society, and the American Association of Pathologists and Bacteriologists, the House of Delegates of the American Medical Association approved and endorsed the following statement, which ought to settle the matter:

"In proposing the following specific recommendations concerning the regulation of clinical laboratories, the joint committee of the American Medical Association, the American Chemical Society, and the American Association of Pathologists and Bacteriologists wishes to emphasize the importance of encouraging and insuring the adequate education of every laboratory worker in the fundamental sciences which he applies. A clinical laboratory—as that term is used by the committee—is an institution organized for the practical application of one or more of the fundamental sciences by the use of specialized apparatus, equipment and methods for the purpose of ascertaining the presence, progress, and source of disease.

"It is the unanimous judgment of the committee:

1. "That it should be illegal for any person not licensed by law so to do, to assume the responsibility of making the diagnosis or of deciding on the progress or source of disease on the basis of any results of a chemical, pathologic, serologic, bacteriologic, radiologic or microscopic observation or other laboratory examinations undertaken; and that where laws do not now restrict diagnosis or the clinical interpretation of laboratory examinations to licensed classes of medical practitioners, laws should be enacted to effect that end.

2. "That any law providing for the licensing of professional workers in laboratories devoted to ascertaining the presence, progress or source of disease should provide for the examination of members of each profession by competent authorities belonging to the same profession.

3. "That as long as an organization or individual engaged in examinations to ascertain the presence, source or progress of disease refrains from all diagnostic and

prognostic interpretation of the results of such laboratory tests, as provided for in paragraph 1, any effort to force such organization or individual to place itself under the direction of a representative of any other profession is to be deprecated.

4. "That the American Chemical Society, the American Medical Association, and the American Association of Pathologists and Bacteriologists should co-operate to establish the principles enumerated in the foregoing resolution whenever legislation in this field may be proposed, and that the co-operation of other national bodies should be solicited.

5. "That clinical laboratories be standardized in accordance with the principles laid down in the preceding paragraphs, and legislation should be enacted to insure competent personnel and suitable equipment."

CALIFORNIA MEDICAL ASSOCIATION AND THE MEDICAL SOCIETY OF THE STATE OF CALIFORNIA

The California Medical Association — The present name of your state association was adopted June 23, 1923, to conform with the spirit of organization.

The Medical Society of the State of California — The former name of your state association, retained by a society voluntarily formed of those members of the C. M. A. who were unwilling to dispense with the services of your legal department when Indemnity and Legal Defense was discontinued as a society undertaking.

Dues—The yearly assessment to each association is $10. The C. M. A. dues are paid through your county secretary. Optional Medical Defense dues are sent direct to the state office.

Alumni New York Skin and Cancer Hospital—Graduates of this post-graduate school are requested to send their present professional office address to the secretary of the reorganized Alumni Association.

DR. HERMAN GOODMAN,
15 Central Park West, New York City.

Veterans' Bureau Service Expanded—It is not very widely known that the last congress passed a law authorizing the Veterans' Bureau to extend its hospital and traveling expense service to include veterans of *all wars since 1897* for certain diseases. Under this law *"any person who served in the military or naval forces of the United States during any period after 1897,* except those persons whose discharge from the service was dishonorable, will be furnished treatment at any hospital under the jurisdiction of the United States Veterans' Bureau, when such persons are suffering from neuro-psychiatric or tuberculous ailments and diseases, paralysis agitans, encephalitis lethargica, amoebic dysentery, or the loss of sight of both eyes. The term 'neuro-psychiatric ailments and diseases' will include psychoses, psycho-neuroses, epilepsy, organic diseases of the nervous system, endocrinopathies, Raynaud's disease, sangioneurotic oedema and erythromelalgia. 'Tuberculous ailments and diseases' will include all forms of tuberculosis."

The New Jersey Medical Association, with a membership of 2300, has engaged, at the expense of about $12,000 a year, a publicity agent or educational instructor, a full-time man. He acts as editor of the state journal, as a chairman of the welfare committee, and will spend his whole time in placing their problems and their matters of medical interest before the medical men of the state and before the people of the community. — A. M. A. Bulletin.

Medicine in the Public Press

An Effective Check to the Socialization of Health—President Coolidge, in his budget message, refers to federal subsidies by saying: "I am convinced that the broadening of this field of activity is detrimental both to the federal and the state governments. Efficiency of the state governments is impaired, as they turn over to the federal government responsibilities that are rightfully theirs. *I am opposed to any extension of these subsidies. My conviction is that they can be curtailed with benefit both to the federal and state governments.*"

In commending the President's stand, the San Francisco Bulletin says editorially that: "If the government is to build the roads, if it is to control education, if it is to be the *universal guardian against disease,* if it is to reforest our hills, and on down the line to *instructing women in the business of maternity,* little will be left to individual initiative and judgment, not to mention *state responsibility.*

Legal Restrictions Embarrass Educator — In a thoughtful editorial (San Francisco Bulletin), Mr. Will C. Wood, State Superintendent of Education, is quoted as saying that he is "getting a bit tired of this eternal saddling of all the problems that civilization can't solve on the school system."

"There are those," continues the editorial, in support of Mr. Wood's contention, "who would make the schools the universal physician, the universal dentist, the universal nurse, the universal provider, the universal entertainer of childhood. There are those who, in enthusiasm for special fads and whims, would make the school, not an agency of instruction and mental training, but a forcing house in support of propaganda in a hundred forms."

"At the next legislature I want to introduce a bill striking out twenty-seven subjects required by law. I would strike out these twenty-seven subjects and in their places insert a few fundamental objects of education, such as lay the basis for all learning that may come later, instilling patriotism and building up character. These would be less easy to tamper with, for the number of virtues is much less than the number of subjects that cranks can suggest. . . . Worst of all is the realization that most of these subjects are but mummified and petrified tributes to the persistence—or beauty—of professional lobbyists in Sacramento."

Mr. Wood ought to have more support than he is likely to get in this praiseworthy objective.

Another Germ Killer—Another professor has discovered another germ killer, according to the newspapers.

This new poison is said to consist of a sort of by-product of the ultra germs that live as parasites upon the ordinary germs that we know about. The ingenious discoverer says his toxin will not kill the tuberculosis germ, but does promptly destroy those of cholera, typhoid, and what not. The modest discoverer apparently considers his work comparable to that of Pasteur.

Let us hope that it is.

An Optimist Writes Fiction — One doctor (variety not specified), according to an editorial (World's Work) predicts that "In fifty years the world will be a world without disease. The most terrible plagues that now afflict mankind will have been conquered by modern chemistry. Even the most baffling will become only the more tragic memories of humankind. A world without disease!" The editor implies wisely that this will require speed because "It would probably be impossible to find today a single human being who is not ill in some way and to some degree."

Every Nut Has a Kernel—"The beliefs of Christian Scientists, so far as they relate to the cause and cure of human disease, are not new revelations in advance of biological science. They are really curious survivals of primitive conceptions, discarded by biologists centuries ago. All primitive people look upon disease as the result

of abnormal 'spiritual' forces. Treatment consists in attempts to expel invading demons, or propitiate angry deities. Christian Scientists have merely reworded these primitive conceptions in terms of orthodox Protestant Christianity."—The Research Worker, Stanford University.

An Important Decision—Attorney-General Webb, according to news dispatches, has ruled that persons licensed as chiropractors and osteopaths are not eligible under the law to receive credentials from the state school department to perform health and development work in the public schools.

Was Everyone Blameless for the Death of Victoria Ortez?—Nationwide publicity was recently given to the incident in Solano County when the little three-year-old Victoria Ortez died as a result of burns after being refused admission and service to two hospitals, one a government institution, the other a private hospital. The incident apparently has now been closed by a finding of the district attorney of the county to the effect that no one was to blame for this accident except possibly the parents. It seems that the child was burned one evening and medical attention was not asked until 10:30 o'clock the next morning. Curiously enough, most of the criticism and newspaper editorial comment throughout the country has resolved itself into bitter criticism of the medical profession as the result of this accident. This, in spite of the fact that none of the evidence shows that any doctor at any time was asked to see the child, or did see it, or knew anything about the situation at all until the child was taken into the hospital where it finally received service.

Some good will apparently come out of the incident, in that the county authorities are now negotiating with the private hospital to take care of emergency work in their locality.

Stockton Doctors Complimented—According to newspaper reports, Mrs. Thompson believes Stockton's physicians to be exceptionally competent in treating tuberculosis. Several of the doctors had their patients and diagnoses checked up at the Tuberculosis Clinic held in Stockton recently.

It is becoming quite the fashion for non-medical persons, state bureaus, and other organizations to call in outside doctors to check up on the work of local physicians in certain communities.

Nutrition Expert Holds Clinic—According to news dispatches, "mothers of habitually underweight children are urged to bring them for examination to Miss Woodward, nutrition expert of the State Board of Health, who will hold consultations in a room separate from the examination quarters of the clinic and will give advice on nutrition and dietetics."

Tulare County Health Center Taken Over by Local Officials—Tulare County Health Center, which has been supported largely by voluntary contributions for some time, has been officially taken over by the county as a municipal undertaking. It is anticipated that everyone connected with the center will now be paid except the doctors, who will be expected to continue their services for nothing.

Optometrists Official Examiners of the Eyes of School Children—Optometrist Fred Watson, secretary of the California Optical Company, claims to hold a certificate from the State Board of Education to examine the eyes of children in the public schools. Upon a recent trip to Pittsburg, Calif., he is said to have examined about 200 children. The examinations were free, so far as the children are concerned, being paid for by the association of optometrists.

Drugless Healers Given Credit for California's Health—An editorial in a California newspaper says:

"The truth of the matter is that California is the most progressive state in matters of health, and the reason why it is so healthful is because it has such an abundance of drugless healers, doctors who do not believe in prescribing drugs and serums to cure 'bad habits.'"

Old Age Pensions—An Old Age Pension bill, known as the Murphy bill, will be considered by the Forty-sixth California Legislature. The bill is modeled upon those of Montana, Utah and Pennsylvania, is fostered by the fraternal Order of Eagles, and has the endorsement of organized labor. It is a substitute for poor farms; authorizes a monthly allowance of $30, to be allocated and disbursed by a state commission to needy persons over 65 years of age.

"Nothing so damns our civilization," says the Daily News editorially, "as the way we treat our aged. Were dependent old age written down as a felony on our penal statutes, we would hardly be more cruel than we are to the aged infirm. For no other crimes than their misfortunes we brand them paupers and herd them into 'poor farms.'"

There, instead of loving care, tender understanding and honor, we dole out a grudging three meals and shelter as forbidding and unbeautiful as a jail.

"Old age, which gave us Moses, Socrates, Epictetus, Erasmus, Tolstoy, Whitman, Anatole France, the seers of every era, must look to China for the veneration it has earned through patient years. California has nothing to offer the aged but a bare living.

"The proposed pension measure would cost no more than the 'poor farms,' and it would permit our old folks to enjoy their declining years among their friends and families."

The principle involved deserves the highest consideration, but like so many other fine idealistic principles it is difficult of practical application.

A wisely drawn and wisely enforced law surely would constitute as definite an improvement over "poor farms" for the aged and permanently disqualified of any age, as does the "home placement" over the "orphanage" for homeless children.

Success in both movements requires careful, wise sustained personal supervision. Many of our elderly dependants are not only physically, but also mentally handicapped, and to give them a cash allowance once a month without thoughtfully applied safeguards would lead to all sorts of undesirable consequences.

The bill deserves serious and careful non-political study by our legislature, and if the principle involved can be made practically workable, it ought to be incorporated into law.

Cancer Cures Below the Average—Only four "new" sure-shot "cancer cures" were given space in the newspapers during the past month.

Are "sure cures" discovered less frequently than formerly, or are editors growing more particular? The latter appears to be the answer, for several of our papers did not mention any of the last four. Other editors gave them brief notice and only a few gave them extensive write-ups.

A Doctor Answers a Patient—In answering a patient's protest against the amount of a fee, a doctor wrote:

"You make the contention that the operation required less than three hours, and that the charge of $—— is, therefore, entirely out of reason.

"Permit me to point out to you a slight discrepancy in your calculation. As a matter of actual fact, the operation to which you refer required somewhat more than twenty-seven years. That is the period of time which I spent in studying my profession and fitting myself to successfully perform an operation in three hours. Like other medical men, I have no source of income aside from my professional services. And I am sure you will agree that it is only fair to add a certain sum which may be credited to experience, and that elusive thing known as "skill." Pro-rated over a period of twenty-seven years, my charge of —— appears ridiculously small, doesn't it?"

"People Who Live in Glass Houses—"—According to "News" dispatches, Mr. Wagner, head of a state bureau, is going to put a lot of private hospitals out of business because they are "veritable fire traps." Why

pick on the private hospitals? If there are any private hospitals worse fire traps than are the *majority* of government hospitals, we would like to see them. Why should the government have a monopoly on the privilege of housing the sick in "fire traps"?

"Propaganda Against Optometry in Board of Health Bulletin"—Under this headline the California Optometrist says: "How widespread and insidious the propaganda against optometry is becoming is evidenced by the weekly bulletin of the California State Board of Health published on September 6, and which contains an article by Dr. Edward F. Glaser of San Francisco, a member of the State Board of Health, entitled 'Saving Eyesight.' These bulletins are given a widespread circulation, and one copy is mailed to every newspaper in the state."

The part of Dr. Glaser's article which is particularly resented by the Optometrist reads: "Be sure that your eyes or your children's eyes are properly examined by a doctor trained and capable of recognizing and diagnosing the actual conditions and who possesses the knowledge and training necessary in applying the proper remedies, whether medical, surgical, or the wearing of glasses. The public should be taught that eye-strain is a medical problem, and that no one without a definite medical education should be trusted with the differentiation between healthy and diseased eyes."

The editor of the Optometrist seems to think this statement is political propaganda directed against optometrists instead of a simple statement of scientific fact. The editor believes: "That doctors and oculists for the past few years have been viewing with alarm the rapid growth of optometry that has long been recognized by members of the profession, and recently many indications have shown that the medical association is planning to make a hard fight against the inroads optometry has been making on the medical profession."

Poor Monkeys — Four-legged and Two-legged — India is becoming so aroused over the slaughter of their four-legged monkeys to secure "glands" for the "rejuvenation" of two-legged monkeys that the Societies for the Prevention of Cruelty to Animals have entered the field. A Calcutta paper is quoted as saying that: "The European and American craze for rejuvenation is denuding India of its monkeys, the sacred animals being slaughtered so that the senile and debauched may win back a problematical youth."

The editorial warns the government that, unless it forbids this "devilish trade," it will have a terrible responsibility when the consequences of the popular indignation become manifest."

Thoroughly Disgusting—An anonymous writer calls our attention to a disgusting lot of newspaper and magazine clippings upon which he (or she) invites comment:

Case 1—Madam X says she is an "expert" upon "nerves" and that she is a "scalp and skin specialist." If she is doing only what she claims, she is practicing medicine. The Board of Medical Examiners will see if they can get enough evidence to at least make her move.

Case 2—A "specialist for ladies" says, in a San Francisco newspaper, that she has had twenty years' "experience" and has "relieved thousands." Perhaps that is one reason why only 87,000 babies were born in California last year.

Case 3—A Chinese herb company makes marvelous claims of the usual kind. The people of this concern are now under arrest, as they have been several times before. So far, it has been impossible to convict them. To publish the reasons might be libelous.

Case 4—"Doctor ——, expert specialist," tells what he can do in many lines. He claims to save the patient money by preparing "medicines in office." The Board of Medical Examiners could perhaps give another reason for his not patronizing a drug store. It ought not to be particularly difficult to get evidence in this instance."

Case 5—Papers in San Diego carry the claims of ——, to the effect that several serious maladies are "easily cured." "Elegant illustrated booklet, 10 cents." The post-office people might be interested in that "booklet."

Case 6—"Cancer victims" are invited to "address physician for circular," says a card in a San Francisco newspaper. We wonder if the newspaper saw that circular before they accepted the responsibility of helping this "physician" promote his scheme.

Case 7—"Dollar Clinic," "all ailments," "medicines included" for a "$1 fee only." Even at this rate they cannot compete with the "free clinics" nor with the Industrial Accident fees.

Case 8—"Doctor ——, spine and nerve specialist," says you can get well quickly by his "soothing treatment."

The newspaper that carries this has just below it (and mixed up with several sorts of healers' conflicting claims made ridiculous by comparison as between themselves) the following:

"The (name of the newspaper) is a member of the Association of Newspaper Classified Advertising Managers, which includes leading newspapers throughout the country, and has for its aim the elimination of *fraudulent and misleading classified advertising*. The ——, as well as every other member of the association, endeavors to print only truthful want ads, and will appreciate having its attention called to any advertisement not conforming to the highest standards of honesty."

Good newspapers, like good doctors, try to live up to their ethics.

Why?—"E. E. Simpson will appear before the state convention of chiropractors," says the San Francisco Daily News. "Mr. Simpson is eating tacks, broken bottles, razor-blades, and electric-light bulbs. He once won a wager by eating an automobile windshield."

Does Dancing Prevent Cancer?—According to newspaper stories, a California doctor "who has just returned from a world-wide research expedition" says that it does. As the story goes, the doctor is quite positive that: "In countries where people dance from their youth, cancer is never found!!!"

A Great Newspaper Attacks "Cancer Cure News"—It is heartening to see a great newspaper like the New York Times publishing articles condemning the propaganda that circulates as "news" about "cancer cures." In an intelligently illustrative article recently carried by the "Times," this irresponsible publicity is classed as a menace.

"This menace lies in the deluge of so-called cancer "cures" which is flooding the country. Some of these cures are advertised with transparently evident commercial design and some are put forward with an attempt to simulate conservative procedure, almost deceiving the medical profession itself. Between the two are many varieties; some are promoted by persons who are so ignorant that their written communications are grotesque—and written communications are frequent in connection with proprietary cancer cures, for the promoters draw their patients from a large territory. . . . No one can fail to appreciate the emotional reaction of a woman who is suffering from what she believes to be a disease with only one end, when she reads in the newspapers that such and such a person has discovered a cure for cancer. She immediately seizes upon the hope that is offered to her, and believes the claims that are made; and the wish, which under such circumstances is so naturally the father of the thought, endows the cure with every virtue its promoter may have forgotten to ascribe to it. And the friends and relatives of patients look on and share in the delusion."

The business of cancer cure fakirs would be promptly reduced 75 per cent if all newspapers would refuse to publish anything about cancer not endorsed by competent medical opinion.

"A university education will be broadcast by radio in Berlin. Similar cases will become common in America later. The majority, of course, want entertainment when they listen in. But there are millions who would welcome the chance to get a college education at night, being

unable to afford personal attendance. Radio and the movies will be the greatest future educators."

United States Government Makes Huge Profits Out of Narcotic Problem—According to official reports, the federal government collected through narcotic taxes for last year $1,057,066.33, and it cost $709,790.66 to administer the law. Therefore, our government got a profit out of its narcotic business of more than $300,000. Many doctors would like to know if it is because of the profits in the business that the government still refuses to modify the war tax on doctors.

Shall Doctors "Unionize"?—It may seem strange to some people that highly educated physicians and surgeons should organize a labor union and fix a scale of wages, but there is nothing either odd or wrong about it. Those Washington doctors who formed such a union merely made use of their intelligence and took a step which ought to be beneficial both to them and to the public.—San Francisco Daily News.

Anaphylactic Shock Following Use of an Organic Coagulant—Bernard E. Sayre, Chicago (Journal A. M. A.), relates a case of a severely toxic goiter in a man, aged 30, in which, after enucleation of the gland, a continual oozing on the left side of the trachea could not be stopped. As the bleeding was very close to the recurrent laryngeal nerve and ligation not practical because of danger of injury to the nerve, an organic blood coagulant (coagulose) was applied to the bleeding surface, the area packed with gauze, and the incision sutured in the usual manner. The blood pressure before operation was 160 systolic and 80 diastolic. During operation it rose to 180 systolic and 90 diastolic, and at the close of the operation the blood pressure had dropped to 165 systolic and 85 diastolic, with a pulse of 120. The patient was breathing well and appeared in good condition. About fifteen minutes after the application of the blood coagulant, the patient suddenly became cyanotic, breathing with great difficulty and inspiring in short gasps. Foam appeared at the mouth. Within a minute or so, breathing ceased. The heart became rapid and the pulse somewhat weak, but continued to beat regularly. Artificial respiration was resorted to; stimulants were given hypodermically; oxygen was administered, and breathing was finally resumed. Cyanosis lasted for ten minutes. The patient remained unconscious for two hours afterward, although ether was not given at any time during the operation, and the gas anesthetic had been stopped fifteen minutes previous to the onset of dyspnea.

The Swing of the Pendulum—It is evident, believes E. H. Oschner, that the pendulum is already beginning to swing the other way and that the older clinical methods are gradually coming back. . . . Some of the refinements in diagnosis and treatment which are now in vogue are unquestionably very interesting to the research worker and in part may ultimately be of some real benefit to medicine. But the questions which the man who actually teaches under-graduate students should ask himself are, "Have they proven their dependability and are they of sufficient fundamental importance for the student to spend his time on in the present stage of his educational career?" While a certain small number of cases require some refined diagnostic methods, in the great majority of cases such ultra-refinement is not necessary and often not desirable because it only too often tends to confuse rather than to clarify. The x-ray in gall-stones, for instance, misleads more often than it aids. Let us remember that, after all, the five well-trained senses are usually indispensable in reaching a correct diagnosis, and let the teacher ever emphasize this point and do everything in his power to teach the student the proper use of these senses; not to the exclusion of the other diagnostic methods, but with the understanding that the percentage of errors in conclusions, based upon a careful examination of a patient by the unaided senses, is much smaller than the percentage of error in conclusions based exclusively upon almost any one of the more modern ultra-scientific diagnostic methods.

California Medical Association

A. M. A. FELLOWSHIP

Fellowship and membership in the American Medical Association are often incorrectly used as synonymous. They are not identical, and members of the California Medical Association are frequently surprised to learn they have not automatically been made Fellows of the A. M. A. by reason of their state membership.

When the county secretary reports a new member to the state association, his name is forwarded to the A. M. A., and he is then listed as a member and not a Fellow of the A. M. A. Should he desire Fellowship, he must make special application for it upon a blank provided, which can be obtained from the state office, 1016 Balboa building, San Francisco. A check of $5 must accompany the application, of which $4 is credited to a subscription to the A. M. A. Journal and the A. M. A. Bulletin. If the A. M. A. Journal is not desired, one of the six publications listed on the back of the application blank can be substituted.

Loss of membership in the state association automatically debars from both membership and Fellowship in the A. M. A.

Only Fellows can actively participate in the program of a national meeting. The right to hold office or to vote is also contingent on Fellowship status. Delegates from the C. M. A. to the A. M. A. must have been Fellows in good standing for the preceding two years.

REAPPORTIONMENT OF DELEGATES TO A. M. A.

(Important letter from Doctor Olin West)

September 27, 1924.

The triennial reapportionment of delegates from constituent state and territorial medical associations was effected at the Chicago annual session of the American Medical Association in June of this year. The reapportionment of delegates was on the basis of one delegate for each 950 members or fraction thereof for all constituent associations having a recorded membership of 950 or more. Under the provisions of the by-laws, each constituent association with smaller membership is entitled to one delegate.

The records of this office show that, on April 1, 1924, the California Medical Association had reported 3929 members for enrollment. The California Medical Association will be entitled to five delegates in the House of Delegates of the American Medical Association in 1925.

There are now pending proposed amendments to the constitution and by-laws providing for an increase in the voting membership of the House of Delegates. It is quite probable, therefore, that a new apportionment of delegates will be effected in 1925.

ANNUAL SESSION C. M. A., YOSEMITE, MAY 18, 19, 20, 21, 1925.

How do we get there and where do we stay after we arrive?

Those are the two big questions in connection with any convention, not excepting those held in such a well-known place as Yosemite. Both will be answered here as briefly and as comprehensively as possible for the benefit of those who will attend the annual meeting of the medical society of the state of California, May 18-21, 1925.

Yosemite National Park, most popular of all the nation's parks, lies almost due east of San Francisco, in the heart of the Sierra-Nevada Mountains, and is reached by railroad and by several good automobile roads. Main lines of both Southern Pacific and Santa Fe, in the San Joaquin Valley, between San Francisco and Los Angeles, pass through Merced, from where the Yosemite Valley railroad leads up the beautiful canyon of the Merced River to El Portal at the park boundary. A government highway that is like a boulevard extends from El Portal fifteen miles farther up the canyon to Yosemite Valley, the heart of the park. The drive from El Portal to Yosemite, as the village is known, is a matter of an hour, in the comfortable motor-cars of the Yosemite Transportation System, one of the most spectacular hours in a lifetime, for the broad road leads through a panorama of cliffs, and forests, and waterfalls that has no superior anywhere in the world.

On this ride, the visitor passes through the famous "Gates of Yosemite," where El Capitan towers 3604 feet on the left, with Three Graces making a perfect background for Bridal Veil Falls on the right, and Clouds Rest and Half Dome looming up in the middle distance.

The rail journey from Merced to El Portal is only seventy-eight miles, a trip of about four hours through famous placer mining country still scarred by the activities of '49. Detailed schedules and fares from all principal points in the state will be furnished later.

The Wawona road, ninety miles from Merced to Yosemite, paved or macadamized for thirty-eight miles of that distance, probably will be the best road for the use of those who will go to the convention in their own machines, as the Big Oak Flat road sometimes does not open until later because of snow on the higher altitudes. However, road conditions depend on the season, and the weekly bulletin of the superintendent of Yosemite Park, distributed to all agencies of the California State Automobile Association and the Automobile Club of Southern California, might well be consulted before starting the trip to ascertain just what roads are open.

Arriving in Yosemite Valley, Sentinel Hotel and Yosemite Lodge will receive the visitors. The Sentinel is situated in the village, while the Lodge is across the river, less than one-half mile distant, in a grove of pines at the foot of Yosemite Falls. Both offer accommodations and service of the highest type, the Sentinel having its living quarters in rooms, with and without private bath, in a main and annexed buildings, and the Lodge having the cabin plan of accommodations, individual houses, with and without private bath, grouped around an attractive community center.

Unobtrusive service and supremely good food have made the Sentinel favorably known to even the most jaded of globe-trotters. It is one of the few hotels in the world electrically equipped throughout, all heating, lighting and cooking being done by hydro-electric power. It also is one of those rare hostelries which are operated on an "unlimited" policy in the kitchen, the chefs being unrestricted in their use of good things, so that the Sentinel justly claims the highest per capita consumption of cream, butter and eggs of any hotel on the Pacific Coast.

Rates at the Sentinel (American plan) are $6 a day per person in rooms without private bath, and $8.50 a day per person in rooms with private bath. All rooms are outside rooms and nearly all rooms are equipped with twin beds.

The cabin type of resort, frequently encountered in the West, has reached its highest development in the American plan accommodations of Yosemite Lodge.

Redwood cabins with private baths, many of the cabins also having screened sleeping-porch, may be had for $8.50 per person per day, American plan. A generous porch gives entrance to a bedroom equipped with twin beds and other furniture of attractive design, and heated by 5000 Watt electric heaters. A dressing-room or large closet provides ample space for hanging clothes. The bathrooms are equipped in spotless porcelain.

Redwood cabins without private bath make up the second group and are furnished similarly to those having baths, except that bowls and pitchers take the place of running water, and small stoves burning fragrant pine or cedar wood are used for heating. The American plan rate is $6 per person per day.

Canvas cabins form the third group—and do not confuse the Lodge's canvas cabins with tents. Canvas cabins here are all that the name implies, houses with canvas for walls. They are floored, of course, and electrically lighted. Entrance is by a screen door, and there are six screened windows with curtains and awnings. Furnishings are similar to those in redwood cabins without bath, and the charge is $1.50 and $2 per day per person on the European plan, or $6 per day per person on the American plan.

Maid service in all classes of cabins assures plenty of clean towels and, in the cabins without baths, fresh water. Hot water for the morning toilet may be had without extra charge by those living in cabins without baths, if they will leave cabin number and hour desired with the Lodge office. Detached baths and sanitary flush toilets are located conveniently.

Reading room, writing room, dining room, broad verandas, soda fountain and curio and news shop are included in the main building of Yosemite Lodge, with outdoor dancing pavilion and theater for evening entertainments just in front. Individual service at table is a feature of the Lodge's American plan dining room, where excellent food is appetizingly served.

Both the Sentinel and the Lodge are near the village, the government pavilion, and other places where clinics and sections will meet, but for the benefit of those who do not wish to walk, a local service automobile will be operated over the floor of the valley, following a regular route just like a street-car, the fare being reduced to 10 cents, for the benefit of the medical society.

Inquiries regarding transportation to Yosemite, trips inside the park to Hetch Hetchy, the Big Trees and Glacier Point, and hotel accommodations, should be addressed to H. H. Hunkins, traffic manager, Yosemite National Park Co., 511 South Spring street, Los Angeles, Calif., who is acting as chairman of the transportation and hotel committee for the convention.

COMMERCIAL EXHIBIT AT YOSEMITE

The attention of the advertisers in CALIFORNIA AND WESTERN MEDICINE is called to the ruling of the executive committee of the California Medical Association, that, owing to the small demand for a commercial exhibit in Yosemite, no special provision for space has been made, but that advertisers in CALIFORNIA AND WESTERN MEDICINE, and *advertisers only*, are privileged to make arrangement for exhibit space direct with the Yosemite Lodge Company, should they so desire. Credentials will be furnished, on request, by the secretary of the California Medical Association.

ALAMEDA COUNTY

Alameda County Medical Association—(reported by Pauline S. Nusbaumer, secretary)—The annual meeting of the Alameda County Medical Association was held December 15, 1924.

F. B. Taylor reported a case of carcinoma of the stomach, the interesting feature being the fact that the x-ray failed to demonstrate the lesion because it was located posteriorly. The clinical diagnosis was confirmed by the necropsy.

The association is indebted to A. C. Siefert for the following symposium on duodenal diverticula: X-ray diagnosis, with lantern slides, A. C. Siefert; surgical aspect,

A. C. Dukes; medical aspect, S. V. Irwin; differential diagnosis, F. B. Taylor.

S. C. Irwin being unavoidably absent, F. B. Taylor incorporated some of the medical aspect in his talk.

A. C. Siefert, in his paper, reported six cases. He stated that diverticula are more common than is ordinarily supposed. The doctor quickly considered pathologically two general types. He claims that the diagnosis is not possible on clinical data alone, but the x-ray examination is necessary, and the fact that diverticula may become inflamed, and enlarged to a considerable size, makes them of surgical importance.

C. A. Dukes said surgery of diverticula of the duodenum differs but slightly from other surgery of the duodenum. He called attention to the difficulties encountered in trying to operate upon small diverticula, because of the difficulty of locating them at the time of operation. Although they may seem perfectly plain in the picture, in operating they are sometimes most difficult to locate, especially posteriorly.

In a recent case, x-ray showed a definite diverticulum about two inches in diameter in the second portion of the duodenum, posteriorly. At operation the diverticulum was found distended with gas to the size 8 x 5 cm., pedunculated, wall very thin, ruptured during dissection. The diverticulum was adherent and was situated under the lower border at the head of the pancreas. Because of adhesions, the diverticulum was exposed with difficulty; it was freed to base by blunt dissection. There was considerable gas, and some contents of a reddish brown-like fluid escaped during the proceedings. Purse-string of plain catgut, two layers; rubber tube drain at site of operation; usual abdominal enclosure. This man made an uneventful recovery.

The lesson we have learned on duodenal diverticula is to hesitate in operating upon all cases. He thinks that judgment should be used in the type of cases to be operated upon.

In his paper, F. B. Taylor said: "The duodenum is the most sensitive viscus in the upper abdomen. It has a richer blood supply, a faster muscular rhythm, and a more rapid chemical activity than any other part of the digestive tract. It is the segment of greatest physiologic activity in that department which is responsible for human nutrition. Furthermore, the duodenum is as sensitive as it is active, and shares the discomforts of its nearest anatomical neighbors when they are in trouble. The diseases of many of the upper abdominal viscera are characterized by one or more symptoms which are parts of a "duodenal syndrome." It is not strange, therefore, that cholecystitis, bile-tract disease, pancreatitis and partial block of the upper jejunum give a similar train of symptoms all depending upon an interruption of the normal gradient of forces present in a healthy digestive tract. The duodenum informs its owner that there is upper abdominal trouble, and collateral signs and symptoms help make the diagnosis. But when the duodenum itself is diseased, so closely is it surrounded by its anatomic and physiologic neighbors, that it may present very little differential symptomatology. That is especially true when the mucus membrane is unbroken, as in diverticulitis. The diagnosis of this condition, therefore, is not a clinical one; it is made by the roentgenologist or surgeon.

Following the scientific program, the chairman of all standing committees and the chairman of each of the commissions, the secretary-treasurer, and president read their reports, all of which were ordered filed. The tellers not being ready to report, the meeting adjourned to the lower hall and enjoyed a social time while partaking of refreshments.

The election, according to the report of the tellers, resulted as follows: President, H. B. Mehrmann; vice-president, J. K. Hamilton; secretary-treasurer, Pauline S. Nusbaumer. Councilors: L. P. Adams, G. G. Reinle, Gertrude Moore, C. A. DePuy, Guy Liliencrantz, and Sumner Everingham. Delegates: C. L. McVey, Pauline S. Nusbaumer, and A. M. Meads. Alternates: F. H. Bowles, Henning Koford, R. T. Legge, C. A. DePuy, A. H. Rowe, and W. L. Channell.

CONTRA COSTA COUNTY

Contra Costa County Medical Society (reported by L. St. John Hely, secretary) — The twenty-fifth annual banquet and election of officers of the Contra Costa County Medical Society was held Saturday, November 29, 1924, at 8 p. m. at the Berkeley Country Club. The following officers for the year 1925 were elected: President, Marguerite Deininger-Keser; vice-president, G. M. Bumgarner; secretary-treasurer, L. St. John Hely. Delegates: U. S. Abbott and Deininger-Keser.

C. L. Abbott was toastmaster. F. B. La Moine spoke on "Drugs." Rev. T. A. Boyer entertainingly responded to "the ladies"; and Mrs. C. R. Blake received a hearty response for her talk on "the gentlemen." Hiram Jacobs, Assistant District Attorney, covered the subject of "Medical-Legal" thoroughly.

The society was indebted to W. A. Clark of Oakland for the presentation of his famous views photographed in actual colors. This feature of the entertainment was worth the "price of admission." The society wishes to thank him for the favor.

The following were present: Doctors and Mesdames U. S. Abbott, Beard, Bumgarner, Clark, Cole (dentist), Carpenter, Cunningham, Hely, Horne, Lipp (dentist), O'Brien (dentist). C. L. Abbott, Blake, Belgum, Breneman, Clara Spalding, J. B. Spalding, Hall Vestal and two daughters, Eleanor Axelsen, Agnes Driscoll, R. N.; Elizabeth Redmond, R. N.; Mrs. H. K. Youd, R. N.; and Elizabeth McKenzie, R. N.

FRESNO COUNTY

Fresno County Medical Society (reported by T. Floyd Bell, secretary)—A meeting of the board of governors was held in Dr. Morgan's office December 16, 1924, at 1 p. m. The following were present: Drs. Cross, Miller, Tillman, Trowbridge, Morgan, T. Bell.

Bills were audited and ordered paid.

Dr. Trowbridge moved, Dr. Miller seconded, that the following resolutions be adopted, that publicity be given in the papers, and that the Supervisors be interviewed personally in regard to this matter. Carried.

"WHEREAS, It has come to the attention of the Fresno County Medical Society that a movement is on foot to rescind Ordinance No. 218 of Fresno County; and

"WHEREAS, Said Ordinance No. 218 contains provisions for the compulsory vaccination of dogs against rabies, and

"WHEREAS, The vaccination of dogs against rabies is the best known method for combating and preventing the spread of rabies, and

"WHEREAS, The rescinding of this Ordinance No. 218 would be a step backward in the progress of preventive medicine by doing away with compulsory vaccination of dogs against rabies, and

"WHEREAS, The rescinding of compulsory vaccination against rabies would undoubtedly lead to serious outbreaks of rabies in the future, and

"WHEREAS, Outbreaks of rabies are a serious menace to the health of the citizens of Fresno County, now, therefore, be it

"RESOLVED, That we, the Fresno County Medical Society, go on record as opposed to any legislation that will rescind the provisions in Ordinance No. 218, relative to the compulsory vaccination of dogs against rabies, and be it further

"RESOLVED, That a copy of these resolutions be sent to each member of the Board of Supervisors for Fresno County."

Dr. Trowbridge moved, Dr. Miller seconded, that the dues for 1925 be $15. Carried.

Dr. Miller moved, Dr. Tillman seconded, that the secretary investigate the matter of associate members of the society so that such men who are qualified may be asked to join. Carried.

Dr. Miller moved, Dr. Bell seconded, that the Chair appoint a committee, the secretary being one, to make necessary changes in the by-laws and constitution to con-

form with the state society. Carried. Drs. Cross, Miller, and Bell were appointed.

A special meeting of the Fresno County Medical Society was held, December 20, 1924, with luncheon at the Hotel Fresno.

Twenty-two members and six visitors were present. Members: Aller, Anderson, Bell, Butin, Goldberg, James, Kjaerbye, G. L. Long, Luckie, Madden, Milholland, McPheeters, Pettis, Pomeroy, Sheldon, Tillman, Trowbridge, and Tupper.

Visitors: Betts, Butin, Seligman, Preston, Woolf, and Mr. J. D. K. Perry of the "Republican" staff.

Dr. C. Mathewson gave a short talk about his visit recently to Los Angeles in regard to the plague situation, and asked this society to give its support to the Board of Health in asking for $5000 for rat eradication in Fresno.

Dr. Luckie moved, Dr. Kjaerbye seconded, that this body, through its board of governors, endorse the request of the Board of Health for $5000 for ridding the city of rats.

The following letter was sent Mayor Hart, in regard to the last-named affair:

"Hon. T. G. Hart, Commissioner of Public Health and Safety, City Hall, Fresno, Calif.

Dear Mayor Hart — The board of governors of the Fresno County Medical Society, meeting December 20, 1924, do hereby endorse most heartily the request of the Board of Health of Fresno for $5000 for a campaign against rats, as this is the most efficient means of preventing plague in human beings, and so avoid, if possible, an epidemic of plague such as occurred recently in another city in California.

Respectfully yours, John D. Morgan, M. D.; D. H. Trowbridge, M. D.; W. W. Cross, M. D.; W. P. Miller, M. D.; E. J. Couey, M. D.; Frank Tillman, M. D. By T. Floyd Bell, secretary."

Dr. M. S. Woolf of San Francisco gave an instructive and interesting paper on "Ulcerative Colitis." He said that this is a rare disease, of non-specific etiology as far as known, but often associated with streptococci. It was just described as an entity in 1883. It is almost always fatal if no surgery is used, while almost 80 per cent are cured by surgery unless very far advanced. The ulceration usually begins in the rectum, and a sigmoidoscopic examination is invaluable. It usually ascends and involves the whole colon and stops at the caecum. Patients die from anyloid disease and perforation. The symptoms are many: watery, bloody, mucous stools, with some cramps. These patients suffer great thirst. Remissions are typical and may last for years. The diarrohea is very severe. Differential diagnosis must be made from amebic infection and bacterial infections, such as tuberculosis or typhoid. The surgical treatment consists in an early enterostomy. The paper was well discussed by Pettis.

The meeting of the board of governors of the Fresno County Medical Society was held in Dr. Morgan's office January 5, 1925. Those present were Cross, Couey, Miller, Morgan, Tillman, Trowbridge, and Bell.

Dr. Trowbridge moved, Dr. Miller seconded, that a committee of three be appointed to confer with the City Commissioners in regard to a rat campaign and to insist that an appropriation of $5000 be made for this work. Carried. Drs. Cross, Trowbridge, and Pettis appointed.

Dr. Miller moved, Dr. Trowbridge seconded, recommending that the secretary's annual report be accepted. Carried.

Dr. Miller moved, Dr. Tillman seconded, recommending that Dr. O. W. Steinwand be placed on the honorary list.

The regular meeting of the Fresno County Medical Society was held January 6, 1925, at the nurses' home of the General Hospital. There were twenty-six members and ten visitors present. Members: Aller, Anderson, Bell, Burks, Couey, Cross, Diederich, James, Jorgensen, Konigmacher, Kjaerbye, Manson, Mathewson, Miller, Milholland, Nedry, Peterson, Pettis, Sciaroni, Sheldon, Stein, Tillman, Tobin, J. R. Walker, Wiese, and Willson. Visitors: Drs. Pierce, Charles Brown, Phillip, Dick, and internes at the General Hospital.

The minutes of the previous meetings were read and approved.

The application for membership of N. J. Dau of Fresno was read and ordered placed in the proper channels for action.

O. P. Pisor of Monmouth was unanimously elected a member, having been passed on favorably by the board of censors and the state secretary.

The following officers for 1925 were elected unanimously, no offices for 1925 being contested: President, A. E. Anderson; first vice-president, W. G. Milholland; second vice-president, Charles A. James; secretary, T. Floyd Bell; assistant secretary, J. A. Montgomery. Delegates: T. F. Madden, H. J. Craycroft. Alternates: B. Lamkin, R. B. Tupper. Board of governors, W. P. Miller.

The secretary's annual report was read and adopted.

Madden moved, Tillman seconded, that O. W. Steinwand be placed on the honorary list.

George Warren Pierce of San Francisco gave an illustrated talk on Plastic Surgery. He said that plastic surgery was much advanced, due to disfiguring and incapacitating wounds of the Great War. Plastic surgery is a crude way and dates back to ancient times as far as 3000 years ago. It was done by the tile craft then. Probably two things have advanced plastic surgery more than anything else in the last few years. They are the tubular and Esser skin grafts. Dr. Pierce showed lantern slides, demonstrating the use of such grafts.

A buffet luncheon was served after the meeting.

A meeting of the board of governors of the Fresno County Medical Society was held January 8, 1925, in Dr. Anderson's office.

Those present were Cross, Couey, Anderson, and Bell.

Miller moved, Cross seconded, that the secretary be authorized to complete arrangements for a speaker to come here in regard to the plague situation and appear before the luncheon clubs; also to prepare leaflets for distributers. Carried.

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KERN COUNTY

Kern County Medical Society (reported by W. H. Moore, secretary) — The annual banquet of the Kern County Medical Society was held at the Elks Club, Bakersfield, December 18, 1924, and the following officers were elected for the succeeding year: William H. Moore, president; A. W. Moodi, vice-president; K. S. McKee, secretary-treasurer; P. J. Cuneo, censor; F. A. Hamlin, delegate; and F. J. Gundry, alternate. The society fixed the dues for the coming year at $17.

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MARIN COUNTY

Marin County Medical Society (reported by J. H. Kuser, secretary) — The annual meeting of the Marin County Medical Society was held on December 18, 1924, in Doctor Jones' office in San Rafael. Present: Dufficy, Jones, Clark, Hund, De Lancey, Kuser. Annual dues were fixed at $11.

Officers elected for 1925 were: President, H. O. Hund; vice-president, W. F. Jones; secretary, J. H. Kuser. Trustees: H. O. Howitt, J. H. Kuser, H. O. Hund. Delegate, R. G. Dufficy. Alternate, C. A. De Lancey.

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MONTEREY COUNTY

Monterey County Medical Society (reported by Wiley Reeves, secretary)—At the annual meeting held on December 5, 1924, the following officers were elected for the year 1925: William Rollin Reeves, president, W. H. Bingaman, vice-president; E. Wiley Reeves, secretary; T. C. Edwards, treasurer.

The delegates for the 1925 convention are: Delegate, E. Wiley Reeves. Alternate, W. N. Bingaman.

Dues of the Monterey County Medical Society were fixed at $12 per member, which includes both state and county society dues for 1925.

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SACRAMENTO COUNTY

Sacramento Society for Medical Improvement (reported by G. J. Hall, secretary)—The regular annual meeting of the Sacramento Society for Medical Improvement was held December 16, 1924, President Dr. Drysdale presiding. Members present, 33.

The minutes of the last annual meeting not at hand, secretary apologized for his delinquency.

Dr. Drysdale, in making the board of director's report, touched upon the important points of the meetings of the past year. Briefly outlined, his paper reported that: 1. Business is not interesting to members. 2. Scientific papers read by local men are most productive. 3. Discussion previously programmed is most active. 4. Interesting cases were reported. 5. There was only one outside speaker during the year. 6. Meeting place discussed. 7. Annual banquet. 8. Eulogy expressed on death of Dr. J. W. James.

S. E. Simmons and George Joyce Hall were appointed to draft a resolution on the death of Dr. J. W. James, to be spread on the minutes and a copy to be sent to Mrs. James.

Secretary's report was read and placed on file.

Drysdale, Cress and Scatena, Dillon, Harris and Dunlap were elected as directors.

Drysdale and Dunlap were elected as delegates; Doctors Hale and Jones as alternates. Dr. Thomas was elected secretary.

It was properly moved and seconded that the dues for the coming year be $15. Carried.

Letter of Dr. J. M. Hamblin, in regard to Industrial Accident fees (addressed to Dr. C. B. Jones), was read to the society and discussed by Dr. Parkinson.

SAN BERNARDINO COUNTY

San Bernardino County Medical Society (reported by E. J. Eytinge, secretary)—The society met at the San Bernardino County Hospital, January 6, 1925. There were 31 members present, 55 absent, 10 guests.

B. R. Davidson of San Bernardino was admitted to membership.

The program was as follows: "Report of a Case of Abdominal Pregnancy, With Brief Discussion"—E. L. Tisinger. Discussion opened by H. W. Mills. "Ectopic Pregnancy"—C. G. Hilliard. Discussion opened by Philip Savage. "The Posterior Occiput Position"—Norman H. Williams, Los Angeles. Discussion opened by H. G. Hill.

The society will endeavor to keep on hand such sera as cannot be procured at short notice from commercial sources. These sera will be kept at the County Hospital for use by any member of this society. Through the courtesy of the Department of Health of New York, we have five bottles of Type A and ten bottles of Type B botulinus serum. Through the Mayo Clinic, we have a small supply of anti-poliomyelitis serum. Attention is directed to the necessity of using the above at the earliest moment. In March we have been promised a tube of rattlesnake anti-venene.

The president has appointed the following as a radio committee: C. L. Curtiss, C. F. Whitmer, and F. F. Abbott.

The secretary acknowledges a communication from the Sophomore Medical Class of Loma Linda, thanking the medical society for inviting them to attend Dr. Pinness' clinic.

Dues for the ensuing year are now payable and are fixed at $15, $10 of which goes to the state society.

SAN DIEGO COUNTY

San Diego County Medical Society (reported by George B. Worthington, secretary)—The annual meeting of the San Diego County Medical Society was held at the San Diego Hotel at dinner December 9, 1924. The meeting was well attended, and was presided over by Doctor Thornton. An invitation to hold the January meeting at Camp Kearny was extended by Major Simpson, chief of staff, and was accepted.

The following officers were elected for the ensuing year: President, G. B. Worthington; vice-president, T. F. Wier; secretary, C. O. Tanner; treasurer, W. O. Weiskotten. Councilors: Marjory Potter, H. S. Anderton, E. F. Chamberlin. Delegate, Martha Welpton. Alternate, Lillian Mahan. Milk Commission: H. A. Barclay, five years; L. R. Knorr, four years; W. W. Russell, three years; T. A. Parker, two years; A. B. Wessells, one year. Library directors: Frank Carter, Eager, Geistweit, Howard, Jennison, Jorgenson, Kyes, Murdock, Pollock, Redelings, Rees, Stallard. Secretary-treasurer, W. O. Weiskotten.

The question of the formation of a publicity bureau was brought up by Thornton, and, after full discussion, an assessment of $10 was levied "to cover the expenses incident to the publication in the San Diego Union of regular weekly articles, in the nature of educational propaganda, which will be able to give the people as a whole a better insight into what medicine is doing and what it is trying to accomplish for the good of the community." A full discussion of this plan appears in the bulletin of the San Diego County Medical Society of December 19.

Doctor P. B. Magnusen of Chicago gave a most interesting, instructive and practical talk, well illustrated with lantern slides on non-surgical types of backache. His paper was discussed by Doctors Fox, Harding, Churchill, and Doig.

At the conclusion of the program, Thornton thanked the officers and members of the medical society for their co-operation and help during the year 1924, and commented particularly on the great efficiency of the program committee.

Mercy Hospital—The fine new million-dollar hospital, financed, constructed, and conducted by the Sisters of Mercy, is now open and serving the people of San Diego. An illustrated description of the hospital, prepared by Doctor Robert Pollock, appears in Better Health magazine.

SAN FRANCISCO COUNTY

San Francisco County Medical Society (reported by J. H. Woolsey, secretary)—The January bulletin of the San Francisco County Medical Society contains the following interesting news:

Radio Medical Talks—The San Francisco County Medical Society has consummated an arrangement with the broadcasting station of the Radioart Studio, Station KFRC, to radiocast health talks and medical information.

Any member of the society may apply to the radio committee for placement on the radiocast program. The names of speakers, their introduction, the subject matter of talks, etc., are all subject to review by the radio committee two weeks before talk is to be given.

KFRC has, to date, broadcasted the following medical talks by members of this society:

September 26, 1924—Outline of health service. Joseph Catton.

October 1, 1924—How other sciences have helped medicine preserve health. E. S. Kilgore.

October 8, 1924—The doctor's biggest job (warding off old age). A. C. Reed.

October 15, 1924—Care of common skin affections. H. E. Alderson.

October 22, 1924—How to live longer. S. H. Hurwitz.

October 29, 1924—Making healthy minds in childhood. W. P. Lucas.

November 5, 1924—Getting thin. Rene Bine.

November 12, 1924—How to avoid cancer. A. R. Kilgore.

November 19, 1924—How prenatal and postnatal care make for future health. W. C. Hassler.

November 26, 1924—How child guidance clinics prevent future failures. R. L. Richards.

December 3, 1924—Why heart disease has become one of the main causes of death. P. K. Brown.

December 10, 1924—How to avoid contagious diseases. A. A. O'Neill.

December 17, 1924—Reconstruction of body parts through plastic surgery. G. W. Pierce.

These talks should take about ten minutes. They are given on each Wednesday evening at about 9 o'clock from the broadcasting station of the Radioart Studio, located at the Hotel Whitcomb.

Advertising Cards of Physicians—The board of directors desires to communicate to the members that it is against the policy of the society to place professional cards in so-called lay directories and other publications serving similar purposes.

The officers elected for the year 1925 are: President, LeRoy H. Briggs; first vice-president, J. F. Cowan; second vice-president, Adelaide Brown; secretary-treasurer, J. H. Woolsey; librarian, Leo Eloesser. Board of directors: Rene Bine, W. W. Boardman, W. R. P. Clark, H. W.

Gibbons, Sol Hyman, William Ophuls, and R. K. Smith. Delegates: W. R. P. Clark and E. S. Kilgore. Executive committee: M. R. Gibbons, chairman; W. J. Kerr, and H. G. Mehrtens. Committee on admissions: Lloyd Bryan, chairman, K. L. Schaupp, and F. H. Zumwalt.

At the meeting of the Eye, Ear, Nose, and Throat Section of the San Francisco County Medical Society on November 25, 1924, the following officers were elected for the ensuing year: Chairman, Otto Barkan; secretary, Warren D. Horner.

The program was as follows:

1. Demonstration of case of intra-ocular copper foreign body—Kaspar Pischel.

2. Paper: "Further Observations on the Use of Adrenalin in Glaucoma"—Kaspar Pischel.

Synopsis—Doctor Pischel, speaking on further observations on the use of epinephrine in glaucoma, pointed out that epinephrine is the official name of the drug; adrenalin is a proprietary name. The solution on the market contains a small amount of chloretone.

Pischel, in relating his own experience in eighteen cases, stated that, in simple and chronic glaucoma, the pupils were always dilated and the tension lowered in complicated cases. Where operation had been performed the results were not uniform.

The dilatation of the pupils is very desirable for ophthalmoscopic examination and in cases of iritis. In the latter cases the injection causes considerable pain. Dr. Pischel then showed a case of glaucoma apparently caused by a piece of copper being lodged in the ciliary body for the last twelve years. It had produced the so-called sunflower opacity of the lens. The greenish opacity of the lens is caused by deposition of copper salts between the capsule and the epithelium. Fundus showed total excavation of disc. Tension was reduced by adrenalin injection of 0.3 from 43 to 30. The pupil, 3 mm., was dilated to 8 mm. The sight was 2/30; field very much contracted. (An attempt to remove the foreign body failed. Cyclodialysis done immediately after this attempt did not reduce the tension; therefore, iridectomy was made several days later.)

Discussion by Dr. Hans Lisser—It is interesting to hear this report, which provides another example of the extraordinary pharmaco-dynamic powers of this remarkable drug adrenalin. It occurs to me that its action in reducing intra-ocular tension, as in glaucoma, bears some similarity to its potency in angioneurotic edema, in giant urticaria, or in the urticaria of serum sickness, where swellings are made to vanish with amazing rapidity.

This beneficent action of adrenalin does not necessarily permit the deduction that we are dealing with an adrenal insufficiency, in the endocrine sense of this term. From this therapeutic effect alone we are not justified in concluding that glaucoma, or, for that matter, asthma or angioneurotic edema, are ductless gland diseases. We could as well diagnose hypopituitarism during labor, since injection of pituitrin hastens expulsion of the fetus.

Nevertheless, an incretory participation either in the origin or sudden appearance of glaucoma is not unlikely. Indeed, such a conception has been supported by several considerations and advanced by several authors. Imre has even suggested determinations of intra-ocular tension as a diagnostic aid in endocrine diseases (this requires further study). Hertel found that patients with hyperfunction of the thyroid have low intra-ocular tension, and patients with glaucoma have signs of hypofunction of the thyroid. In a case of pregnancy, complicated by osteomalacia, Imre found an extraordinarily low tension of 5 mm. Hg., lower than that of a cadaver. Fridenberg considers glaucoma from the endocrinological point of view as an exudative or hypersecretory disturbance due to sudden failure of vagus tone under sympathetic irritation.

In any case, no final judgment is possible at present as to the role played by the ductless glands in the pathogenesis of glaucoma. Experiments are much to be desired that would forge a binding chain of evidence between such disconnected links as endocrine activity, vagotonia, sympatheticotonia, protein sensitivity, acidosis and calcium deficiency as exemplified in asthma, hay-fever, rhinorrhoea, urticaria, angioneurotic edema, glaucoma, and migraine and epilepsy.

Dr. W. S. Franklin suggested that the injection should not substitute operative measures which accomplish their object in a large number of patients.

Dr. Otto Barkan—We have tried glandular extracts in a number of cases of glaucoma without results. In one case of glaucoma associated with a vascular neurosis, hypodermic injections of adrenalin lowered intra-ocular tension for from several hours to a day. We have found that subconjunctival injection of adrenalin is particularly useful in iritis with secondary glaucoma, inasmuch as it lowers tension and dilates the pupil at the same time.

Dr. George Hosford—We have had essentially the same results as Dr. Pischel on cases at the University of California clinic.

Dr. Pischel, in closing, stated that injection is no substitute for operations in glaucoma, but is a great help for the control of glaucoma in its different stages, and also as a preliminary to operation or to examination.

3. Paper: "Further Observations in the Use of Thyroid in Incipient Cataracts"—George N. Hosford.

Synopsis—Twenty-four patients with senile cataract of various degrees of maturity were treated over a period of from three to twelve months with thyroid substance (Armour) in doses of from 3 to 6 grains.

Fifty per cent of the patients showed improvement of 0.1 or more. Thirty-seven and one-half per cent showed no change, while 8 per cent became distinctly worse. One case improved in one eye and became worse in the other. The greatest improvement obtained was from 0.3 to 0.6. This was in a man of thirty-eight, who took large doses over a long period. In one patient not included in the above series, a man of forty-seven, with incipient cataract in both eyes, had a needling done in the left eye six months before we saw him. The absorption of lenticular material seems to have been remarkably accelerated by thyroid substance in doses of 3 to 6 grains per day. In two patients with secondary cataract, the results were negligible. We intend now to try pure thyroxin and also parathyroid substance. Discussion was opened by Dr. W. J. Kerr.

Dr. Hans Lisser stated that Hosford's admirable paper deserves hearty commendation. No flamboyant claims are made; it exemplifies a sincere effort to arrive at truth by thorough methods of study. Determinations of the metabolic rate are desirable if for no other reason than to discover in which patients an actual thyroid deficiency is being supplemented by the thyroid extract administered. In those patients with normal rate, the beneficial action would have to be interpreted as that of a tissue stimulant, a metabolic tonic. We have by no means exhausted the possibilities of thyroid therapeutics as a general tonic, in which respect it is far more potent than iron, quinine, or strychnine, though it must be used with exceeding care. I am not inclined to think that any of the improvement noted was due to a possible admixture of parathyroid material. We are only certain of one clinical entity due to parathyroid insufficiency, namely, tetany, and there are no authentic instances where this condition has been relieved by the use of any of the commercial parathyroid preparations available. Parathyroid extracts in the treatment of tetany are in the same position that pancreatic extracts were in the treatment of diabetes before the discovery of insulin. Their use was logical, but they were impotent. When an active parathyroid extract is discovered its trial in the treatment of cataract will be indicated, since cataract is an important complication of tetany, and has been experimentally produced in animals (Erdheim) by removal of the parathyroids.

It is indeed true that trophic degenerations affecting the skin, hair, teeth, nails and lens are characteristic of senility, quite in the same way as are thickenings of arteries and degenerative changes in kidney, brain, and heart. Is it sound reasoning to assume that these gradual gradations of decay are due to endocrine disease and, therefore, amenable to organotherapy? Is it not more reasonable to believe that the ductless glands are sharing in the agine process in the same degree and simultaneously with all other tissues of the body? Is it sound practice to attempt to whip the weary old horse into a ridiculous

and dangerous gallop? Might it not prove to be his last spurt when he might have walked for some time longer?

This is no criticism of the use of thyroid extract in cataract except as it may suggest a distinction between the true senile cataract of good old age and the cataract of a premature senility. And herein lies the kernel. A premature senility, a cataract between 30 and 50 years of age, is quite a different matter. Such premature decay is most likely due to disease processes of thyroid, pituitary or gonads, that have aged the glands before their time. Here most certainly do we have indication for glandular therapy. Meanwhile a judicious trial of thyroid extract in the treatment of cataract, in conservative dosage, under very careful supervision, may prove worth while, as indicated by this excellent preliminary paper. Both Dr. Kerr and Dr. Shepardson deserve credit for their important share as physicians in aiding the study and observation of these patients.

4. Paper: "Submucous Resection Without Packing"—Rea E. Ashley.

Summary—Since operation of resection of the nasal septum was first described, various methods and materials have been used to keep the flaps in apposition and to prevent hematomata.

The three most popular methods are: 1. Packing (innumerable materials have been used). 2. Use of metal clips. 3. No packing whatever.

This paper deals with the last method, giving technique and reporting eighty cases done without packing.

Summary—1. It is not necessary to pack. 2. Results are just as good or better without it. 3. Convalescent time is cut down. 4. Patient is much more comfortable. 5. There is less danger of complications.

Dr. Wallace Smith stated that he always uses Bernay Simpson tampons. He sees no particular advantage in not packing.

Dr. A. C. Gibson agrees with Dr. Ashley. For three years he has not packed a nose except in one case of an anomalous artery crossing the sphenoid. Other discussants were Drs. Pischel, Fletcher, Price, and Ashley.

St. Joseph's Hospital Staff, San Francisco, was addressed on January 14 by Sister Dionysia, directing dietitian, on "The Aims of the New Dietetic Department." Dietetics was declared a factor in preventive medicine and food idiocyncrasy discussed. Investigative methods described were dietary study, respiratory quotient, carbon and nitrogen determination and calorimetric estimation—the last being stressed—and all showed striking consistency. Two thousand to 3300 calories daily, according to muscular exercise, was declared sufficient. Construction of diet is determined by the patient's weight, height and condition, and on a maintenance diet there is some gain in weight. Preliminary laboratory examinations and a test diet are required. Special diabetic, nephritic and other therapeutic diets are ordered by the doctor and the dietitians care for it in the diet kitchen. The tray is carried to the patient by the nurse in the diet kitchen, nothing being added by any Sister or nurse. The foods are weighed before and after eating. New diet charts were explained, the principle being to individualize the dietary, as is done for each patient in any other branch of medicine and surgery. A stubborn case was quoted in which the patient could not be made sugar-free until it was discovered that he was taking sugar-coated pills.

Dr. R. M. H. Berndt presented a case history of a patient with nephritis and cardiovascular complications.

Dr. E. C. Fleischner spoke on "Indications and Contraindications for Tonsillectomy." He divided children into two groups—those under 5 years and those over, stating that in the younger the lymphatic tissues of the tonsils are more active in developing immunity, and there should be more definite reasons for removal. Redness of the anterior pillars and small granulations at the reflection of the mucous membrane from the anterior pillars to the uvula are definite signs of disease and disappear after tonsillectomy. Simple hypertrophy is often nature's way of increasing the bactericidal power of the tonsil and, unless it obstructs breathing, should not prompt removal. Deep abscesses in the tonsil are indications for removal, as are also involvement of regional lymph glands and a history of diseased tonsils, malnutrition without other cause. otitis media, repeated upper respiratory inflammation, chorea, erythema nodosum, acute arthritis, if teeth are good, and repeated follicular tonsillitis or quinsy. Do not operate, ordinarily, during acute diseases, even cervical adenitis. An exception is a monarthritis—if teeth are good. When the resistance is lowered by acute lesions, tonsillar infection tends to cause septicemia, while after the resistance is regained the lesions remain localized. Endocarditis, if chronic and not due to other focus, especially with glands, and acute hemorrhagic nephritis following tonsillitis after the nephritis has subsided, justify tonsillectomy. Under 5 years tonsillectomy is in order with repeated otitis media or tonsillitis, acute arthritis (monarticular), and obstruction to breathing. Simple hypertrophy, even with lymph glands, should be delayed to a later age, when the function of the tonsil is not so necessary. Roy Parkinson opened the discussion and advised tonsillectomy for diphtheria carriers and hoarseness also, and compared the merits and demerits of the operation. Ethan Smith gave some of the failures from it in joint lesions. Harold Wright touched upon tuberculosis as an indication and contra-indication. E. C. French mentioned asthma with negative protein reaction as an indication. He also reported upon St. Joseph's Hospital clinic, and H. B. Dixon stressed the need of social service for it.

The program for February 11 follows: "Post-operative Cardiac and Pulmonic Therapy," A. W. Hewlett; and "Treatment of Surgical Post-operative Complications," C. A. Walker.

Sisters Appreciate Doctors' Aid—The Sisters of St. Joseph's Hospital deeply appreciative of the favor shown them by the hospital staff in voluntarily assisting them in giving the hospital publicity in the advertising pages of CALIFORNIA AND WESTERN MEDICINE and Better Health, wish to express their gratitude to all for their manifestation of loyalty to St. Joseph's Hospital. The Sisters hope that the doctors' work may be blessed with success throughout the year, which they feel will be a happy one for all.

Southern Pacific General Hospital Clinical Meeting (reported by W. T. Cummins, secretary)—The regular monthly meeting was held at the General Hospital, San Francisco, on Wednesday, January 7. Subject: "Diseases of the Thyroid."

1. Medical Aspect—Hans Lisser illustrated a number of cases of thyroid disease, including goiter, myxedema, etc., and spoke of specific medication in each, with especial reference to the effect of iodine in goiter. The associated pathology of other endocrine tissues was discussed. Obesity in pre-adolescent life was commented upon as being probably always of endocrine origin.

2. Surgical Aspect—Wallace I. Terry spoke of the early determination of goiter districts in consequence of the deficiency of iodine in the formation of the superficial stratum of the earth's surface. He reviewed the technique of operation and discussed the different phases of the pathology of the thyroid gland, including hyperplasia, adenoma, carcinoma, and thyroiditis. Much stress was laid upon the value of iodine, as Lugol's solution or some other assimilable iodide, in conjunction with operative procedure.

3. Projectoscopic Demonstration of Specimens—Edwin I. Bartlett demonstrated a large number of slides illustrative of the various types of thyroid disease. The importance of the consideration of the gross pathology with the microscopic was emphasized. The infrequency of sarcoma was noted.

SANTA BARBARA COUNTY

Santa Barbara Cottage Hospital—The fourth annual clinic day of the Santa Barbara Cottage Hospital was given by the staff on Monday, January 12, 1925. The morning session, from 8 to 12, was devoted to an Eye, Ear, Nose, and Throat Clinic, and also a Major Surgical Clinic. After a luncheon, served at the hospital, the Medical Clinic held an afternoon session in the new staff room.

An interesting program, following the annual dinner of the Santa Barbara County Medical Society at the Hotel Carrillo, completed the day.

YOLO COUNTY

Yolo County Medical Society (reported by John D. Lawson, secretary)—The quarterly meeting of the Yolo County Medical Society was held in the reception room of the Clinic Building, Woodland, on January 6.

The following officers were elected for 1925: President, Thomas E. Cooper, vice-president, Moses W. Ward; secretary-treasurer, John D. Lawson; delegate, Fred R. Fairchild; alternates, W. E. Bates and M. W. Ward. Dues were fixed at $12.

E. Eric Larson, associated with the Mayo Clinic for the past four years, is now connected with the Woodland Clinic staff, in the Department of Urology and Surgery.

The Woodland Sanitarium has just acquired a half block of property facing the present building on the south. Plans for further expansion are now under consideration.

H. D. Lawhead was reappointed County Physician and Health Officer for 1925.

At a special meeting held October 23, 1924, the following motion was unanimously adopted: "All patients are to be charged regular office rates for prophylactic smallpox and diphtheria measures, except indigent cases, which are to be cared for by county health officers, with the assistance of members of the society." There was considerable discussion on this subject, in view of the large amount of free prophylactic treatment which has been given previously, it being felt by the members that the physicians should give no more free service, except in indigent cases, than in any other type of medical practice.

Clinics have been inaugurated by the Woodland Clinic staff: Children of pre-school age, Tuesday, 2 to 4; school age, Thursday, 2 to 4; adult free clinic, Wednesday, 2 to 5.

Doctors C. H. Fairchild and Fred R. Fairchild are on a two months' leave of absence. Both are engaged in special work in the East and Middle West.

The monthly clinical conference of the Woodland Clinic was held in conjunction with the quarterly meeting of the Yolo County Medical Society. The following papers were presented: "Treatment of Sprains, Bruises and Minor Injuries"—W. E. Bates; discussion opened by E. Eric Larson. "The Use of Nitrous Oxide in Obstetrics"—N. M. Salter; discussion opened by W. J. Blevins. "An Unusual Case of Pellagra"—F. P. McManus; discussion opened by J. Edward Harbinson.

Don't wait for your county secretary to dun you for medical society dues. They should be paid NOW.

CHANGES IN MEMBERSHIP

New Members—Eugene H. Hull, J. A. Patterson, San Bernardino; Edgar C. Lee, San Diego; Walter E. Whalen, K. S. Davis, Zoe M. Ruth, Los Angeles; D. L. Burgeson, La Habra; Reginald F. Grant, A. M. Moody, Isabella M. Clinton, San Francisco.

Transferred—Fred W. Loring, Albert G. Bower, from Fresno County to Los Angeles County; Eugene W. Whitney, from Los Angeles County to San Diego County; William R. Dorr, from San Francisco County to Riverside County.

Deaths—Bridge, Norman. Died at Los Angeles, January 10, 1925, age 80. Graduate of Northwestern Medical School, Chicago, 1868, and Rush Medical College, Chicago, 1878. Licensed in California in 1891. Dr. Bridge was a member of the Los Angeles County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

Joseph Louis Howard. Died at Honolulu, December 29, 1924, age 55. Graduate of Cooper Medical College, California, 1900; Royal College of Surgeons, England, 1902; and Royal College of Physicians, London, 1902. Licensed in California in 1900. Dr. Howard was a member of the San Francisco County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

Lewis, J. Perry. Died at Honolulu, December 29, 1924, age 58. Graduate of the General Medical College, Chicage, 1895. Licensed in California in 1896. Dr. Lewis was a member of the San Diego County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

McArthur, Newbern Turner. Died at San Francisco, December 31, 1924, age 42. Graduate of Cooper Medical College, California, 1912. Licensed in California, 1915. Dr. McArthur was a member of the Napa County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

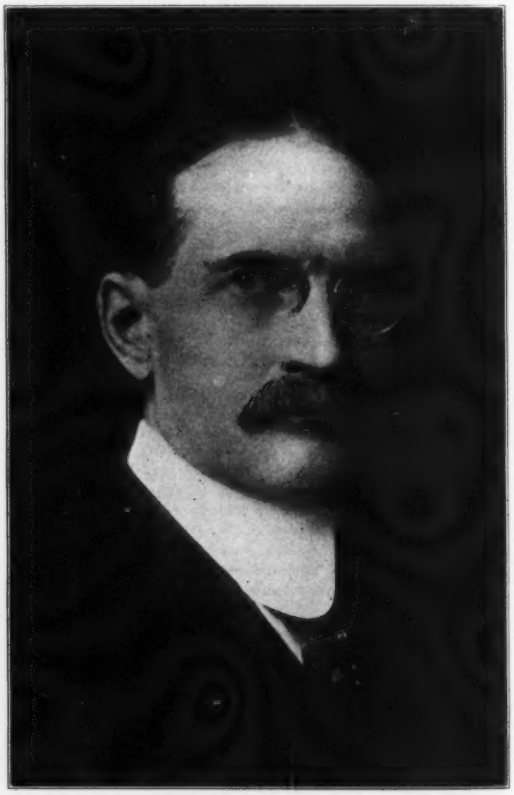
Sewall, Charles Albert. Died at Los Angeles, January 7, 1925, age 75. Graduate of the University of Pennsylvania School of Medicine, Philadelphia, 1872. Licensed in California in 1899. Dr. Sewall was a member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

New Health Officers—John Anthony Azevedo, M.D. (Stanford, 1923) of Hayward has been appointed Public Health Physician of Alameda County. Doctor Azevedo is licensed to practice medicine in California, but is not a member of the California Medical Association.

Mr. Frank B. Wilcoxon has been appointed Public Health Officer of Pacific Grove. So far as we know, Wilcoxon is not licensed to practice.

Harry J. Willey, M. D. (Univ. Med. Coll. Mo., 1904), of Porterville has been appointed Public Health Physician of that city. Doctor Willey is licensed to practice medicine in California, and is a member of the California Medical Association.

George Parrish, M. D. (Missouri Med. Coll., 1894), of Portland, Ore., has been appointed Public Health Physician of Los Angeles. Doctor Parrish has been licensed to practice medicine in California. He is a member of the Oregon Medical Association.



J. PERRY LEWIS, M. D.
1866-1925

When word was received in San Diego during the holiday week that Doctor J. Perry Lewis had died in Honolulu, where he had gone with Mrs. Lewis and friends for

a brief vacation, it saddened the hearts of hundreds throughout Southern California, for Doctor Lewis was a popular and beloved man.

Temperamentally, he was an ideal physician and brought to bear upon the problems of a heavy practice a fund of rare qualities not acquired in college. Graduating in Chicago in 1895, he came to California the following year and has practiced continuously in San Diego since that time. Possessed of a genial and attractive personality, the outward expression of a warm Christian character, he rapidly became prominent in his profession and was soon confronted with the problem of how to take life more easily. For several years he had endeavored to lighten the burden by limiting himself to the specialty of diseases of the nose and throat; yet he had built up such a multiplicity of connections—social and professional—that this but partially lightened his load. He made time for golf—his chief recreation—which undoubtedly helped to keep him physically fit to "carry on"; but no constitution could forever withstand such demands upon it, and he died a martyr to his profession as surely as any more spectacular hero. He was an ex-president of the San Diego County Medical Society, being in office when last that organization entertained the state society. His quiet courtesy and pleasing greeting will be remembered for many a day by his fellow-members of the local profession.

R. P.

STIMULANTS, DEPRESSANTS, HUMOR

Apropos of an editorial in the last number of the Journal entitled "Doctor, Heal Thyself," the epitaph on the slate tombstone of a Dr. Preston in the Colonial graveyard in Keene, New Hampshire, may interest you: "He healed others, himself he could not."—Emmet Rixford.

A darky called at a hospital the other day and said: "I came to see how mah friend Joe Johnson am getting along."

"Why, he's getting along fine," the nurse answered; "he's convalescing now."

"Well," said the darky, "I'll jest set down and wait till he's through."

"As an alumnus of our State Medical School I wish to enter a vigorous protest against some of the advice being given in a health service said to be conducted by a department of our school. I particularly resent the propaganda advising parents to take their children to "psychologists," "child guidance clinics," "habit clinics," in preference to doctors who have been taught and licensed to practice.—San Francisco.

The Pathology of Osteopathy

"But, my dear, aren't these osteopaths rather—I mean to say—intimate in their manipulations?"

"Oh, yes. I had to become engaged to him for the course of treatment!"—Judge.

". . . I am enclosing a clipping from the so-called health column of a San Francisco newspaper. The author seems to think much of Bernarr McFadden, osteopaths, chiropractors and Christian scientists as doctors. Can anything be done about it?"—Sacramento.

Note—The important item of the clipping makes a comparison in mortality statistics from influenza as follows:

"The M. D.'s lost one case in sixteen, the osteopaths one case in 128, the chiropractors one in 300 approximately, while Christian scientists and naturopaths lost an even smaller percentage of their cases. I will not vouch for the authentic accuracy of these figures as given, but I know that these ratios obtained approximately, and I know that the more doping, serumizing, feeding and 'treating' of any kind given in acute diseases, the higher will be the death rate."

No Competitors

"Who done make de best cord tire?"

"De Lord."

"De Lord?"

"Sure! He done make de spinal cord. Dey last a lifetime."

". . . the disgusting propaganda widely published recently as 'news' about the bloodless radio knife said to be so effectively employed at the U. C. Hospital is enough to make every doctor who has studied at that institution blush for shame."—Oakland.

Utah State Medical Association

SOL G. KAHN, Salt Lake City.....President
WILLIAM L. RICH, M. D., Salt Lake.....Secretary
J. U. GIESY, 512 Felt Bldg., Salt Lake City,
Associate Editor for Utah

WHEN IS AN AD NOT AN AD?

The poor we have always with us. In that respect the poor are not unlike the doctor who tries to chase the devil of the dollar around the ethical stump. Shaving the line closely, he eschews a professional card in a daily paper with uplifted palm of horror, but he has a card on a hotel register, sandwiched between that of a laundry on one side and a popular-priced eating joint on the other. He—purely as a matter of fraternity—runs a similar card in the paper of some lodge or similar organization, and sits back to await, or at least to hope for, results. Ethically, maybe he can still get away with it. I don't say he can't. But in this day and age it smacks a bit of a mental state that should not characterize medicine of the highest type. And medicine should be high today, higher than ever in its aims and ideals. Long, long years ago it was said, "By their fruits ye shall know them." And the best "ad" any medical man can use in his walk of life is *works*—the results of his endeavors to deserve the title he wears. Then may he be proud to wear it; then may it be to him a badge of distinguished service; then will he find little need to advertise in the commonly accepted understanding of the word.

PEDIGREED BUNK

Without taking a leaf out of Uncle Billy's Whizz Bang, the phrase is not without application to the medical profession of the present day, and is largely the cause of the flourishing condition of the cults. Let us stop and take an inventory of ourselves. Barnum remarked that the public liked to be fooled. That's bunk also, of course. The truth is that the public doesn't like to be fooled, but that it doesn't always know that it is being fooled, because the public doesn't always know what it's all about.

We as a profession are seeking to do good work. Nobody can truthfully challenge the fact, but, in our enthusiasm over our own advancements, our own investigations and endeavors, we are overlooking in a large measure the very thing that a few years ago made the old family doctor what he was—a man with a hold on his clientele, next only to that of the priest—friend and advisor as well as medical servant—wise man, kindly man, to be looked up to and given full trust.

Nowadays the average man at least tries to use his head. He likes to know what is being done to him or for him, rather than treated too much as an erudite problem in metabolism, which is a word conveing nothing to his intellect. Here it is that the cults get in their work and sell their pedigreed bunk. They at least make him feel that they are appealing to his intelligence. The assumption may be flattery, of course, but flattery is one way of selling the prospective buyer, none the less. Hence, it's time that we as a profession got back to the old-time basis

of understanding co-operation between doctor and patient, insofar as the ideal may be obtained in the individual case.

Wise looks and reticence may appeal to the occasional man. He may be content to go forward in a childlike faith. But the majority will respond far better to an understandable explanation of what is being done for him, a brief and comprehensible exposition of what the medical profession is today actually doing for the race. Surely, we may tell of the real, the far-reaching results of our own work and progress, as well and as advantageously as the cults with their pseudo-science camouflaged in words.

Let's get back into the personal contact with our patients on the personal basis, drop the oracular attitude and sell ourselves as our grandfathers sold themselves and their profession to the multitude of loyal and trusting clients whom they served. After all, it is the personal element, the personal contact, that lies back of all real human associations from the cradle to the grave. Let's fight the pedigreed bunk of the cults with the living truth. Let's spend a few more words on the individual patient to win his intelligent, understanding confidence.

Utah Notes (reported by J. U. Giesy, associate editor for Utah)—The banquet scheduled for December 29, in honor of Doctor Salathiel Ewing, one of the oldest physicians in the state, was regrettably canceled, owing to the poor health of Dr. Ewing. He is past 90 years of age, and is in the hospital at present.

R. R. Hampton, councillor for the Second District, has resigned, on account of ill health. J. C. Landenberger of Salt Lake City was appointed by the council to fill Dr. Hampton's place.

Dr. William Rich returned from the meeting of the secretaries of the A. M. A. In his report he says:

"The program committee has asked me to give a brief report of the transactions of the last annual meeting of the secretaries of the Constituent State Medical Association held in Chicago, November 21 and 22.

"There were present thirty-seven state secretaries; twelve editors of journals and officers of the American Medical Association and board of trustees. The most important paper was presented by Frederick C. Warnshuis, secretary of the Michigan State Medical Association and speaker of the House of Delegates, who outlined a definite plan of action for 1925, which was approved by the board of trustees. Briefly, the plan was to formulate a better understanding of, first, The American Medical Association; its history and development; its plan of organization; Constitution and By-laws; its administration features, including its work and achievements; and the service it renders to the physician; and explanation in detail of its publications; of the requirements of fellowship and the benefits of fellowship. Second, the state society organization; its activities; its membership, qualifications and benefits. Third, the individual's responsibility to county, state and national organization; to fellow-practitioners; to the community and to humanity.

"To briefly review some of the things brought out in this paper and its discussion, one must begin with the unit of the national organization, the County Medical Society, of which there are 3047 in the United States. Some of these units have as few as four or five members and some as many as several hundred. But, each has certain officers; board of censors; various committees and members, and a constitution and by-laws. These units go to make up the various state associations. The state associations are organized the same as the county society, but have, in addition, a House of Delegates and councilors, representing councilor districts. The function of the council is to act as the executive body of the association between meetings of the House of Delegates.

"Its function is to aid in co-ordinating the work done by the county societies and through the work of its various committees to keep in touch with the needs of the profession and humanity in the state. To hold annually a scientific meeting available to all members of the component county societies of the state and to transact such business as is vital to its well-being.

"In addition most of the state organizations publish a state journal, in which papers from the various county societies and the proceedings of the annual meeting, including the scientific papers, appear. The smaller states join together and two or three or four are represented by one journal, as is the case with us in Utah.

"The national organization is similar to the state organization and has its headquarters near the center of population. Like the state, it has its officers and board of trustees instead of councilors, a House of Delegates and various committees and bureaus and section officers, Fellows and members. It publishes and edits several scientific journals, owns its own buildings and equipment, which is worth over $1,000,000. It is the largest and most powerful organization of medical men in the world. It has a membership of 90,000 members, 55,000 of whom are Fellows. It has a reserve fund of over three-fourths of $1,000,000, and we ought to be proud of our membership in it.

"Probably the greatest piece of constructive work performed by the national organization is the work done by the Council on Pharmacy and Chemistry. Nostrums of a few years ago of the rank type have mostly disappeared. The aid of the council is now sought by investigators and manufacturers before they attempt to offer any medical product to physicians. The problem of this department is now more concerned with biologic products as therapeutic agents. This department, through the chemical laboratory, has aided greatly in the standardization of drugs. The activities of the propaganda department are far greater than at any time in its history. Thousands of letters from laymen, lawyers and doctors are received and answered by this department each year. This department has also conducted a clipping bureau and is furnishing articles to many magazines and journals whose subscriptions total over 1,000,000. It has furnished such journals with articles from Hygeia, and you will find them appearing regular every month in certain magazines. It has furnished educational posters, stereopticon slides for public health work in schools and colleges. It has also given the committees on scientific research certain grants in money to various institutions and physicians to aid in research. Sixty-one grants, amounting to $1500 for 1923.

"The Bureau of Legal Medicine, which was created two or three years ago, is now in full running order and can give to county or state associations legal advice on medical subjects. This department, through Doctor Woodward, keeps the various state associations informed regarding national legislation affecting the profession. Like the state association, the national body holds an annual meeting in some city selected by the House of Delegates. Its scientific meetings are divided into sections representing the various specialties. All members may attend these meetings, but none but Fellows may hold office or participate in the deliberations of the assembly. It is possible some of you may not clearly understand the difference between fellowship and membership. If you join your county society you automatically become a member of the state association and the American Medical Association, but no part of your dues goes to the A. M. A. Therefore, you are not supporting in any financial way the national organization. But if you subscribe to any one of its publications a part of that subscription will go to fellowship dues, providing you make such known by filling out an application for fellowship. Many of you probably have the opinion that you must subscribe for the A. M. A. journal. That is not necessary, providing you subscribe for some other journal, such as the Archives of Otolaryngology, American Journal of the Diseases of Children, Archives of Neurology and Psychiatry; Archives of Internal Medicine, Archives of Dermatology and Syphilology, and Archives of Surgery.

"The national organization is also aiding the profession by way of educating the public through the public health journal, Hygeia. This seems to be not greatly appreciated by the profession, as only 14,000 out of 90,000 are subscribing for it. The journal has a circulation of about 30,000, and is published at a loss of over $15,000 a year. This little journal was gotten up to fight our battles with humanity, and gives us a better standing in the com-

munity. It will help to keep away state medicine and help us to get better and more just laws. It will help us to make the cults impossible. It is excellent reading for any physician. It should be kept on the library table in every physician's and dentist's waiting-room. It should be in the hands of every school teacher, and some one of our profession should be present at every state teachers' convention to speak of its merits.

"The national organization will soon have completed arrangements to give post-graduate work to our county societies. The details have not been worked out, but the board of trustees has ordered the officers to prepare for it. Periodic health examination was urged by Dr. Albert E. Bulson. I want to say that if the county society does not perform this duty to the public, lay organizations will hire a physician for a comparatively small salary and make the examinations at a good profit for themselves. So we must keep this in mind and be prepared to take it up.

"The Utah State Industrial Commission affairs stand out as a bright and shining example to other states. You are all familiar with it, so the details will not be gone into. The board of trustees authorized the business manager of the association to provide an official automobile emblem that may be copyrighted and used by members of the A. M. A. only."

M. M. Critchlow, secretary of the Salt Lake County Society and members of the United States Veteran's Bureau of Salt Lake, has gone to U. S. V. Hospital No. 98, Castle Point, N. Y., to attend the Government School of Tuberculosis. A class of sixty men will be in attendance at this intensive course of instruction in tubercular conditions for a period of two months. During Dr. Critchlow's absence Lester J. Paul, director of the local Veterans' Bureau, will act as secretary of the Salt Lake County Society.

The state legislature is now in session. We understand that a bill is being prepared for presentation, giving the chiros the right to treat all industrial injury cases by the well-known procedure of twisting or otherwise assaulting the spine. If the legislature passes the thing, it will be one of the heaviest blows to the chiros ever dealt in the state. Time is a thing that both reveals and cures many things. In other words, it "adjusts" a great many badly adjusted affairs.

It might be of interest to the members not in the local vicinity to know that Salt Lake County Society has done much in the Industrial Commission activities, thereby helping to create a favorable feeling between the Commission and the profession in the state. The state society has been in the habit of appointing a board of three members to act as a board of review in association with the Commission for the purpose of passing on cases before the Commission for settlement. These members are necessarily drawn from the local society because of expediency due to their local residence, and all men serve without compensation, being appointed in rotation from the local society ranks. All this has resulted in a very friendly attitude, and we believe that it has done much to secure just settlements and general satisfaction during the last few years. This is a real service which those who serve on the board are rendering both to the profession and to the social structure of the community itself.

At this time the erection of an eight or ten-story professional building in Salt Lake City seems assured. The building committee has opened the books for subscriptions from the profession, and are meeting with encouraging success. Such a building is bound to come and will fill one of the greatest professional needs.

Seymour B. Young, M. D., 1837-1924—Dr. Seymour B. Young, pioneer physician of Utah, died at his home December 15, 1924. He had been in poor health for several months.

Doctor Young was born in Kirtland, Ohio, October 3, 1837, son of the late President Joseph Young and Jane Bicknell. His father was the elder brother of President Brigham Young.

He was graduated from the Medical College, New York University, in 1874, receiving the bronze medal as third honor student of his class out of a total of 208.

Dr. Young was probably the oldest college graduate in the state of Utah, a record in which he took great pride. His success as a physician is attested by the fact that hundreds of people tell of the great worth of Dr. Young in years gone by as a man of medicine. No physician ever administered greater comfort to his sick than he did. His very spirit was one of happiness and hope.

James Monroe Dart, 1840-1925—Dr. James Monroe Dart, one of Utah's oldest practicing physicians, is dead, at the age of 85, at his old home in Roxbury, N. Y.

Dr. Dart came to Salt Lake City in September, 1881, from Elizabeth, N. J. At that time he had already been graduated for years from the College of Physicians and Surgeons in New York City, following that with studies in homeopathy, and had been practicing for a considerable time. He opened offices in Salt Lake City and soon enjoyed a large practice.

In addition to being a brilliant medical man, Dr. Dart was declared to have been unusually learned along other lines, having a vast fund of information on many subjects. Perhaps the outstanding thing about the decedent was his love for music. His hobby was collecting old violins. He was regarded as an expert on rare violins and corresponded with collectors of this instrument in all parts of the world. He always had a number of instruments in his possession and, while not a brilliant performer himself, could play creditably.

Weber County Medical Society (reported by R. L. Draper, secretary)—At the meeting of the Weber County Medical Society held at the Reed Hotel, Ogden, December, 16, 1924, F. K. Bartlett presiding, the following officers and delegates were elected for the ensuing year: President, E. M. Conroy; vice-president, W. R. Emmett; secretary-treasurer, R. L. Draper. Delegates: Eugene H. Smith, Ezra C. Rich, E. P. Mills, F. K. Bartlett. Alternate delegates: Henry W. Nelsen, A. Z. Tanner, G. G. Moyes, L. S. Merrill.

Minutes of the Salt Lake County Medical Society (reported by L. J. Paul, acting secretary)—The regular meeting of the Salt Lake County Medical Society was held at the Salt Lake Chamber of Commerce, Salt Lake City, January 12, 1925, President John Z. Brown presiding. Members, present, 41; visitors, 3. Clinical cases, 2.

Burtis Robbins presented two clinical cases, showing the results of his plastic operations on the face with a unique apparatus designed to cover the defects caused by the loss of one eye. The apparatus is constructed attached to a pair of spectacles. He was assisted in its construction by Dr. Creed Hamand, dentist of this city.

The scientific program consisted of a paper by Joseph H. Peck on "Infectious Jaundice in Tooele County." He effectively outlined the subject from his own practice, showing the infectious nature, the great loss of time experienced by school children, and stated that it was endemic in Tooele County. No fatalities. Discussion by J. U. Giesy, S. D. Calonge, and H. S. Scott.

William L. Rich, secretary of the state association, gave an excellent report on the meeting of the secretaries of the constituent components of the American Medical Association. General discussion followed on the points mentioned in his report by S. H. Allen, T. F. H. Morton, E. F. Root, A. A. Kerr, S. D. Calonge, E. M. Neher, and James P. Kerby.

The subject of a full-time physician on the payroll of the state for work with the Industrial Commission was discussed at some length. It was decided, however, that our present plan of rendering free consultation and assistance to the State Industrial Commission was the most satisfactory. A motion by Fred Stauffer, to the effect that members of our society be paid for their services with the Commission, was lost.

Applications for membership were received from Alfred Blumberg and Edward Day and referred to the board of censors.

The following committees were appointed for the coming year:

Community Clinic—George W. Middleton, chairman; A. J. Hosmer, E. M. Neher, William L. Rich, Willard Christopherson, F. E. Straup.

Building—Fred Stauffer, chairman; E. F. Root, W. R. Calderwood, M. M. Nielson, H. P. Kirtley.

Public Health and Legislation—Sol G. Kahn, chairman; S. D. Calonge, T. F. H. Morton.

Library—W. R. Tyndale, chairman; B. E. Bonar, F. J.

Curtis, E. D. LeCompte, Joseph E. Jack, F. B. Steele, F. A. Goeltz, R. T. Richards.

Dr. Fred Stauffer reported on the subject of a banquet for Dr. Salathiel Ewing, who is now receiving treatment in a local hospital. It was moved by Dr. Stauffer that the money received to finance this banquet for our oldest honorary member be donated to Salathiel Ewing by the individuals contributing. Motion carried. The secretary was instructed to receive the contributions of all members willing to so divert their donations in this manner.

California Association of Physiotherapists (reported by Beret Stenvig, local secretary)—The uses of the mercury quartz lamp formed the subject of the meeting of the San Francisco branch of the California Association of Physiotherapists held on December 10 in the Medical building.

Dr. B. F. Deering spoke on its use in children's diseases, giving reports and conclusions on his work at the children's clinic at University of California Hospital. Bronchial conditions, asthma and undernourished children were among the cases which he stressed as showing interesting results from the use of the mercury quartz lamp. During the course of the treatments in all cases a close check is kept on these three points: weight, appetite, and relief of symptoms. A marked increase in weight and appetite has been gained in almost all cases. The general experience has been an improvement of symptoms after six or eight weeks of treatment. While no permanent and definite cures under the quartz lamp treatment have yet been established with asthma, there has been a decrease in the severity of the attacks and a decrease in the number of colds. His conclusion is that the mercury quartz lamp assists very materially in building up the child's resistance, a factor of great value in combating conditions of that type.

Miss Beulah Rader of the Marine Hospital, with a wide experience and a variety of patients from which to draw her conclusions, talked on quartz lamp technique and gave case reports on patients treated with the lamp.

The meeting of January 14 was devoted to a symposium on arthritis, with the discussion from three different standpoints. Dr. William J. Kerr spoke from the medical standpoint, Dr. H. H. Markel from the orthopedic, and Dr. Thomas J. Crowley from the electrotherapeutic.

Dr. Kerr gave a wide and interesting classification of the various types of arthritis with the medical treatments indicated. In addition, the treatment consists in seeking any foci of infection and removing it if possible, increasing the nutrition if underweight, and reducing if overweight.

Dr. Markel, in speaking from the orthopedic standpoint, gave detailed descriptions of all the various casts and methods of applying for inducing immobilization of a joint to relieve the pain. He also described some operative procedures where such were indicated and the methods and positions for ankylosing a joint when such was desired.

Dr. Markel and Dr. Kerr were of the same opinion, that physiotherapy, in the form of heat, massage and manipulations, was of great value in the treatment of arthritis after the stage of acute inflammation and pain had passed, to increase the nutrition of the tissues and prevent deformities and ankylosis. Dr. Markel emphasized the fact that physiotherapy in such cases should be employed with care and that manipulations preferably be given once only during the treatment and as much within the limits of pain as possible.

Dr. Crowley gave a different slant on the subject by discussing diathermy and galvanism. Both are given only after the chronic stage is reached. Diathermy is given daily for one-half hour, its benefits being in a hyperemia within the joint which results in increased metabolism. With galvanism, the effects are chemical. The positive pole is usually used because it is sedative in action and will introduce chemicals into the body at a given point. Along with this treatment he stressed the importance of accelerated elimination.

Nevada State Medical Association

W. M. EDWARDS, M. D., Mason.....President
CLAUDE E. PIERSALL, M. D., Reno.....
Secretary-Treasurer and Associate Editor for Nevada

Washoe County Medical Society (reported by Henry Albert, secretary)—The Washoe County Medical Society met in regular session in the rooms of the Chamber of Commerce January 13, 1925, President Vinton A. Muller presiding.

Program—Henry Albert presented a paper on "The Newer Knowledge Relative to the Etiology and Prevention of Scarlet Fever." He discussed especially the Dick test and immunization by means of toxin of the specific streptococcus. The paper was discussed by Tees, Morrison, Pickard, Lewis, and Robinson.

J. A. Fuller presented a paper on "The removal of Foreign Bodies From the Eye." In addition to the common forms of foreign bodies, he emphasized especially certain ones of local Nevada interest, such as sawdust and cactus spines. The paper was discussed by Robinson, Barrows, and Brown.

H. J. Brown presented a paper on "Post-Operative Treatment." Emphasis was placed on enemas instead of purging doses of castor oil. The treatment of shock, paralytic ileus and retention of urine was also considered. The paper was discussed by Lewis, Caples, and Bath.

Unfinished Business — Dr. M. A. Robison mentioned what progress was made in securing data as to the value of the work done under the Sheppard-Towner Act. He also stated that the defects in the hospital bill which passed the last legislature, but which was declared unconstitutional, had been remedied, and that the corrected bill would be again introduced in the coming session of the legislature.

New Business—The following visiting staff (to serve for one year) for the State Hospital was appointed by the president: Donald MacLean, surgeon; S. K. Morrison, physician; J. L. Robinson, otologist and rhinologist; C. E. Piersall, roentgenologist; W. L. Samuels and M. A. Robison, anesthetists.

Attendance—Members: Albert, Barrows, Bath, Brown, Caples, DaCosta, Fuller, Lewis, Morrison, Muller, Pickard, Piersall, Robinson, Robison, Servoss, and Tees. Guest: Professor Peter Franssan.

New Committees of Nevada Medical Association (reported by C. E. Piersall, associate editor)—The following appointments were recently made by the president-elect of the Nevada State Medical Association:

Membership—B. Brown, Yerington; A. C. Olmsted, Wells; C. C. Bullette, Las Vegas.

Judicial—M. A. Robison, Reno; R. A. Bowdle, Ely; A. J. Hood, Elko; A. R. Craig, Tonopah; Horace J. Brown, Reno.

Scientific Work and Program—V. A. Muller, Reno; J. C. Ferrell, Fallon; A. Huffaker, Carson City.

Necrology—Mary H. Fulstone, Smith; Donald Maclean, Reno.

Council—S. K. Morrison, Reno; A. L. Stadtherr, Reno; Hal L. Hewetson, Las Vegas; P. D. McLeod, Tonopah; J. T. Reese, Yerington; William Brennen, Eureka; William Howell, Gardnerville; Charles E. Sweezy, Winnemucca; F. M. West, Lovelock; M. J. Rand, Ely; William Riley, Gold Hill.

Entertainment—C. E. Secor, Elko; W. A. Shaw, Elko; J. R. Eby, Elko.

Public Health and Education — Henry Albert, Reno; W. A. Shaw, Elko; M. R. Walker, Reno.

Military Affairs — The president, vice-president, and secretary.

California Board of Medical Examiners

(Reported by C. B. Pinkham, Secretary)

The judgment of the Federal Court in Sacramento, which some months ago sentenced Stuart N. Coleman, M. D., to five years of hard labor in the federal penitentiary, following his conviction of a violation of the narcotic law, was upheld by the United States Circuit Court of Appeals, and as a result Dr. Coleman must serve the sentence imposed. A hearing has already been held before the Board of Medical Examiners to show cause why his license to practice in California should not be revoked, and final disposition will be effected at the February, 1925, meeting.

Gertrude Steele, licensed in California by the 1909 Act as a naturopath, reported fugitive on a Los Angeles manslaughter charge, which is alleged to have arisen following the death of one of her "beauty patients," has been served with a citation by publication, calling her before the Board of Medical Examiners at the February, 1925, meeting to show cause why her license to practice in California should not be revoked. According to recent information, she has been located in Oberhausen, Germany. The records of the board show that other deaths are alleged to have followed her "beauty treatments." Not long since, a Los Angeles Superior Court was reported to have handed down a judgment for $2500 damages, and at about the time of Gertrude Steele's sudden departure for parts unknown a suit for damages for $50,000 was reported filed in the Los Angeles courts, each as the result of her so-called "beauty treatment."

Leon Hurwitz, licensed to practice in this state several years ago on diploma, reported confined in the federal penitentiary, Leavenworth, Kan., November 1, 1924, under sentence of three years, has been served with a citation to show cause why his license should not be revoked at the February meeting, based on his conviction of violation of the Harrison Narcotic Act.

James W. Richards, who recently plead guilty in the Federal Court of San Francisco to a charge of violation of the Harrison Narcotic Act, and sentenced to two years' imprisonment in the federal penitentiary at Leavenworth, Kan., has been cited to show cause why his license should not be revoked at the February meeting based on his record of conviction. Dr. Richards is alleged to have forged the name of a San Francisco physician to a prescription for narcotics.

A complaint has been filed with the board, charging Joseph Sanford, D. C., licensed as a drugless practitioner, with violation of Section 14 of the Medical Practice Act, the complaint having been filed by George D. Gillespie, D. C., Clarence G. Burt, D. C., and Harry C. Bond, D. C., alleging that Dr. Sanford made misstatements in connection with his application for a drugless practitioner license to practice in California.

James Warburton, M. D., has been called before the board in connection with the diploma mill conspiracy cases.

Robert W. Renwick, M. D., alleged to have protected an unlicensed chiropodist named Roy Finney, who, operating a chiropody stand on Main street, Los Angeles, is asserted to have so thoroughly "baked" the feet of a patient that gangrene resulted and the patient later died. It is reported that, about a year ago, Roy Finney was sentenced in Department 2 of the Los Angeles Police Court to pay a fine of $200 or serve 180 days in the city jail. Appeal pending before Superior Court Judge Carlos Hardy of Los Angeles.

The following physicians and surgeons have been called before the board at the February, 1925, meeting to show cause why their licenses should not be revoked on complaints alleging narcotic violation: James T. Fisher, M. D.; James J. Martin, M. D.; and Newton J. Rice, M. D.

Charles R. Knox, M. D., and Peter McGrath, M. D., have been cited on complaints, charging violations of Section 14 of the Medical Practice Act.

Unlawful use of the prefix "Dr." resulted in a fine of $100 recently imposed on Jules Marton, following his plea of guilty in a Los Angeles court.

Petition for the release of Dr. Ephriam Northcott from San Quentin prison, on a writ of habeas corpus, has been denied.

The extradition of Dr. J. W. Peacock to the state of Georgia, granted by Governor Richardson some time since, was nullified by the Superior Court of San Diego, which ruled in favor of the physician on a writ of habeas corpus, thus denying Georgia extradition.

Public records and other matters in the office of any public officer are at all times during office hours open to any citizen of the state, according to newspaper reports of a recent opinion of Attorney-General U. S. Webb.

"Dr." J. Oscar Francis Haas, who is reported to have been sentenced to serve two years in San Quentin for obtaining money under false pretenses, and in 1919 to having been arrested in San Diego under the name of "Rev. J. O. Francis Haas, divine healer," accused of charging one of his patients $4800 for treatments, recently plead guilty in Los Angeles to a violation of the Medical Practice Act. He was reported to be in possession of a diploma from the St. Louis College of Physicians and Surgeons, but the secretary of the college reports no record of Haas.

ACKNOWLEDGMENT OF REPRINTS

Belt, A. E.
See Mathe, Charles P.

Bunnell, Sterling. Reconstructive Surgery of the Hand. Reprinted from Surgery, Gynecology and Obstetrics, pp. 259-274, September, 1924.

Culver, George D.
See Montgomery, Douglass W.

James, Charles S. Operative Fractures. Reprinted from the Journal of the Iowa State Medical Society, September, 1924.

Keenan, Alexander S. Mistakes in Surgery. Read before the San Francisco County Medical Society, September, 1923.

Kilduffe, Robert A. The Clinical Utilization of Leukocyte Counts, With Special Reference to the Use of Graphic Reports. Reprinted from the American Journal of the Medical Sciences, October, 1924, No. 4, Vol. CLXVIII, p. 502.

Kuhns, Ralph H. The Significance of Meningeal Symptoms in Children, With Reports of Two Cases. Reprinted from Archives of Pediatrics, Vol. XLI, No. 9, September, 1924.

Lee Brown, R. K.
See Player, L. P.

Mathe, Charles P. Carbuncle of the Kidney. Reprinted from California and Western Medicine, December, 1924.

and A. E. Belt. A Case of Bilateral Pyelitis Due to the Bacillus Pyocyaneus. An Unusual Kidney Infection Diagnosed Through Ureteral Catheterization. Reprinted from The Journal of Urology, Vol. VIII, No. 4, October, 1922.

and Player, L. P., and Lee Brown, R. K.
See Player, L. P.

Montgomery, Douglass W. The Itch Mite and Its Burrow. Reprinted from Archives of Dermatology and Syphilology, October, 1924, Vol. 10, pp. 473-477.

and Culver, George D. Verruca of the Nail Fold. Reprinted from Archives of Dermatology and Syphilology, October, 1924, Vol. 10, pp. 425-428.

Perrine, J. K. M. Instrument for Removal of Debris in Cataract Extraction. Reprinted from the American Journal of Ophthalmology, November, 1924, Vol. 7, No. 11.

Player, L. P. Lee Brown, R. K., and Mathe, C. P. The Causative Organisms and the Effect of Autogenous Vaccines on Cases of Chronic Prostatitis. Reprinted from The Journal of Urology, Vol. X, No. 5, November, 1923.

and C. P. Mathe. A Study of Tumors of the Vesical Neck and the Prostatic Urethra and Their Relation to the Treatment of Chronic Prostatitis. Reprinted from the Journal of Urology, Vol. V, No. 3, March, 1921.

Shuman, John W. Hydatid Brain Cyst. Reprinted from the Medical Journal and Record for July 16, 1924.

Sutton, Irwin C. A Concise History of Syphilis. Reprinted from the American Journal of Syphilis, Vol. VIII, No. 1, January, 1924.

Too Many Rats—"There are as many rats in this country as there are people, and the total yearly damage they cause amounts to $200,000,000. It would take the labor of 200,000 men to produce the material eaten and destroyed by these rats. It would require about 5,000,000 acres to produce the grain they destroy. They are also the perpetrators of plague."—Dearborn Independent.

Medicine Before the Bench

Findings and Comments of the Courts on Acts and Omissions of Doctors

[EDITOR'S NOTE—*The law reports contain many interesting decisions, involving the reputations and fortunes of doctors. In this column in each issue a brief summary of one or more decisions and comments of the several courts of last resort upon the cases will appear. The matter will be selected by our general counsel, Hartley F. Peart, who, with Mr. Hubert T. Morrow, attorney for Southern California, will contribute from time to time.*]

The liability of a physician for the performance of an unauthorized operation upon a patient was involved in a decision wherein the Supreme Court refused to reverse the judgment and verdict of the jury in favor of the plaintiff and against the physician for $14,332.50. It appeared from the evidence that plaintiff consulted her physician with reference to a perforation in the lower portion of the drum membrane in her right ear, and a large polyp in the middle ear. An operation was advised and plaintiff consented to this operation and was placed under an anesthetic for that purpose. After the plaintiff was anesthetized the defendant made a thorough examination of her left ear and found it in a more serious condition than her right one. The physician then decided to operate upon the left ear instead of the right, the operation being successfully and skillfully performed. Plaintiff claimed that the operation greatly impaired her hearing, seriously injured her person, and, not having been consented to by her, was wrongful and unlawful, constituting an assault and battery.

Upon appeal, in refusing to reverse the verdict of the jury against the doctor, the court quoted, with approval, the language of a former decision, wherein a physician was held to have wrongfully removed the ovaries of a patient, saying:

"'Under a free government, at least, the free citizen's first and greatest right, which underlies all others—the right to the inviolability of his person; in other words, the right to himself—is the subject of universal acquiescence, and this right necessarily forbids a physician or surgeon, however skillful or eminent, who has been asked to examine, diagnose, advise, and prescribe (which are at least necessary first steps in treatment and care), to violate, without permission, the bodily integrity of his patient by a major or capital operation, placing him under an anesthetic for that purpose and operating upon him without his consent or knowledge. . . . The patient must be the final arbiter as to whether he will take his chances with the operation, or take his chances of living without it. Such is the natural right of the individual, which the law recognizes as a legal one. Consent, therefore, of an individual, must be either expressly or impliedly given before a surgeon may have the right to operate.' There is logic in the principle thus stated, for, in all other trades, professions, or occupations, contracts are entered into by the mutual agreement of the interested parties, and are required to be performed in accordance with their letter and spirit. No reason occurs to us why the same rule should not apply between physician and patient. If the physician advises his patient to submit to a particular operation, and the patient weighs the dangers and risks incident to its performance, and finally consents, he thereby, in effect, enters into a contract authorizing his physician to operate to the extent of the consent given, but no further. . . . The medical profession has made signal progress in solving the problems of health and disease, and they may justly point with pride to the advancements made in supplementing nature and correcting deformities, and relieving pain and suffering. . . . The methods of treatment are committed almost exclusively to the judgment of the physician, but we are aware of no rule or principle of law which would extend to him free license respecting surgical operations. . . . "

The Gorgas Memorial—Medical editors have been asked by the executive committee of the Gorgas Memorial to publish a lengthy appeal for support of the movement. In addition to what has already been repeatedly published, the document states that, "inasmuch as the Gorgas Memorial is primarily a medical movement, it must have the united support of the profession if it is to make the proper impression on the general public."

The directors announce the very praiseworthy idea to make of the General William Crawford Gorgas Memorial "not one of marble or bronze," but a permanent living organization in the form of a great health foundation typical of his work in "research and curative medicine."

We presume that Gorgas' really great work in preventive medicine was accidentally omitted from the publication.

"If the medical profession is to maintain the high standing to which centuries of labor in behalf of suffering mankind entitles it, it is essential that a definite organized effort be made to familiarize the public with such facts as will impress upon it the importance of medicine's contributions to human welfare.

"One of the objects of the Gorgas Memorial is to furnish a channel through which 'better health' information may be disseminated. This, says the committee, "cannot be done by individual physicians. It must be conducted by a dignified, ethical organization, controlled by the medical profession. The name of Gorgas is synonymous with *'better health.' No more appropriate name could be adopted for a movement that has for its object the development of co-operation between the public and scientific medicine for the purpose of improving health conditions by implanting the idea in the mind of every individual that scientific medicine is the real authority in all health matters, and as such should be recognized as the source of health instruction.*"

California physicians will appreciate such an indorsement of both an idea and a name under which they have conducted for years a magazine (Better Health); a syndicated newspaper service (Better Health Service) and have for longer years conducted a better health crusade for every citizen we could reach.

Our physicians will feel that it is rather late for any organization to be talking of "adopting" the name Better Health, already well established and protected by priority, usage and law.

"Every doctor is requested by the governing board to take a personal interest in the Gorgas program and to see that his community is adequately represented on the state governing committee. Those invited to serve as founder members of the state governing committees are requested, as they accept membership on the committee, to subscribe $100 to the Endowment Fund, payable within two years."

The organization is controlled by a large board made up of physicians, government officials, and laymen. Doctor Franklin Martin of Chicago is chairman of the board and Doctor Ray Lyman Wilbur of California appears to be the one representative of Western America.

"Many persons think that education is something that we may give a child," says Angelo Patri (Liberty). "No power on earth can do that. Education is something that a child must take. He takes it up from the earth and transforms it into intelligence by the experiences that he gathers through his nerves and muscles—and his *hands*.

"We have one United States Senator who believes Mrs. Eddy was a deity," says J. E. Dildy (Texas Medical Journal). "The banker carries an Irish potato for rheumatism; the congressman signs the Tanlax ad., while the legislator votes for the chro and "totes" buckeyes for piles.

"The doctors of a community can tell the people what to do in order to prevent disease, but they are powerless to enforce their advice," says the Long Island Medical Journal.

Medical Economics and Public Health

Medical Society Dues—At the recent meeting of state medical association secretaries held in Chicago it developed that some states have medical society dues of as much as $25 per year, and there are a number of states that have dues of $15 per year. The general opinion from these states was that doctors do not object to dues if they really are getting something for the money expended, and in the states where the dues are $25 per year many of the doctors have said: "Raise the dues to $50 per year if you can do any more than you are doing now." . . . "Isn't it ridiculous for doctors to offer complaint concerning the insignificant sum asked for medical society dues for an entire year when the average doctor will spend more than that amount in one night for entertainment at the theater, and does not bat an eye to pay ten times as much as a penalty for frivolity of one kind or another."

Everyone Practices Public Health—Every citizen has his effect on the comfort, health and safety of others, and so he practices public health. Every voter practices public health when he supports or opposes the budget of the health department. Every mother practices public health when she either isolates her child who has a cold, or conceals the sickness while she makes her own diagnosis and takes the child to the movies in order to amuse it.—Frank Overton, in Health Quarterly, New York.

Thus Did Athens and Rome Fall—"Today we are spending on our asylums, hospitals and jails more money on the various grades of mentally subnormal children and adults, imbeciles, morons, and border-line cases, than on those of normal mentality."—The Canadian Medical Association Journal.

Does Loose Prescribing Mean Loose Thinking?—"The patient is often told to 'eat a simple diet and take care of his general hygiene,' and then he is hurried out," insists G. H. B. (The Commonwealth). "This often does not mean any more to the doctor than it does to the patient. It is surprising how varied is the layman's interpretation of the modern slogan 'green vegetables.' Some feel that it includes potatoes, rice, and even macaroni. 'Regular exercise, preferably out of doors,' may be as freely recommended to the steeple jack as to the stenographer, and probably means no more to the one than to the other. A classic example of the impossible is for the woman with seven children to 'go home and keep off her feet.'

"Again," says the author, "how little foundation in known fact is there for much that is advised. What should we say as to the consumption of water in the obese? How about the hoary prejudice against water with meals, lest the saliva and gastric juice be diluted? Is it not better to drink at meals than not to drink at all? In one place it happened that one examiner was giving almost the identical diet to the overweights that another was giving to the underweights, and in not a few points it was impossible to decide which was right. Many sins are committed in the name of constipation from the cannon ball to the cold prune floating in the glass of water before breakfast. Just what is 'roughage' and may its use not be abused? What is the normal bowel rhythm, once in eight or forty-eight hours, or is there really any such rhythm? Is it better to pound the pavement in the fresh air or exereise in a gymnasium? Just why is hot food better than cold? How much sleep is 'more sleep'? One might go on indefinitely. But in the presence of the health examination, does it not behoove us all to take down and thoroughly inspect and dust and even selectively discard our old store of hygienic generalities."

Are We Converting Industrial Accident Laws into Compulsory Health Insurance for Everybody?—There seems to be a spirit of active competition between the Industrial Accident Commissions of several states as to which can excel in spreading the provisions of the laws over the largest and most complete set of diseases. Additions of new diseases to the compensable list are occurring very rapidly, and at the present rate nearly all diseases will be compensable within a few years.

"Riveters' osteomyelitis," said to be an "industrial cousin" to painters' colic, was recently added to the list in California.

Newer Ideas in Health Service—One must read widely and extensively these days to keep up with the innovations designed to extend health service to humanity.

Some of these influences and ideas seem sound and are calculated to improve health service and at the same time make it more economical. Others are but indifferent gestures and some are obviously calculated to serve the promoters rather than the public.

One of the newer and apparently promising ideas is being crystallized into what is called "The Physicians and Surgeons' Institution of Chicago." A group of 200 well-known physicians and specialists have organized themselves into a diagnostic service to be operated in connection with a good hotel. Patients will reside in their hotel during the period of study unless and except for a brief period, when they may occupy space in the "Institution" for special study.

The institution "will provide for accurate and complete diagnosis through the finest obtainable equipment and physical plant. The working organization includes a staff of full-time men, and a consulting staff of specialists of recognized ability."

"*This institution is not going to treat any one,*" says the Illinois Medical Journal. "It will be merely as perfect as possible a piece of mechanism available for any physician, irrespective of location, to use in achieving the best possible results for his patients, *without having* the patient leave the *control* of his own physician. This institution will be the public servant of every qualified, honest doctor, as well as of the public, and will be pledged to the most efficient assistance in the most economic manner."

"Larger hospitals will be benefited from this new organization through referred cases. Smaller hospitals will gain appreciably because, lacking an expert laboratory staff of their own, that of this institution, will be in readiness to aid diagnosis.

"Physicians at any point in the United States will find help here. The scope of this institution will be widespread, as any doctor anywhere may refer for diagnosis any of his difficult cases secure in the knowledge that the cases will not be retained, but the case and the diagnosis will be returned to this doctor, and the treatment he sees fit to give will be a matter between himself and his professional conscience."

Sound Investments—Under this title, the Anglo-London-Paris Company, advertisers in CALIFORNIA AND WESTERN MEDICINE, have issued an attractive little booklet for persons who wish to secure quickly concise descriptions of many western, municipal, irrigation and corporation bonds.

Committee of Massachusetts Legislature Recommends Shortening Nursing Education—A committee of the Massachusetts legislature, after studying the whole question of education and licensure of those engaged in serving health, has recommended that the legal requirement for nursing education be reduced to two years and that no legal standing be given to either chiropractors or midwives.

The List of Compensable Diseases Still Expanding—The latest addition to the list is *infected mosquito bites.* The beneficiary, under the recent decision, was a mouth-breather. While asleep, he was bitten on the tongue by a mosquito and the wound became infected.

Step by step we are bringing more and more diseases into the compensable class under the Workmen's Compensation Act. The rulings of the Commission are all that delays more or less complete state medicine in California under the screen of an industrial accident law.

Are You Educating Your Patients in Health?—Almost everyone is busy "educating" everyone else about how to keep well and how to treat disease. Doctors know that fully 75 per cent of this "education," whether pre-

sented by spoken or written word, is unreliable, inapplicable, dangerous or mischievous. Increasing numbers of other intelligent people are rapidly approaching the same inevitable conclusion. We are destined to see the end of the "fad" within a few years, after which physicians and nurses will again have more to say to their patients individually about health as a peculiarly personal matter requiring personal service and publications supervised by medical men will largely occupy the field of general health advice. The time is about right for physicians to take advantage of the situation by more energetically and intelligently carrying forward a system of health instruction for their own patients than has been the custom.

As Doctor Le Grand Kerr (Medical Economics) so well says: "Your patients want health instruction; they seek it from you first of all, but failing in that will seek it elsewhere.

"Very often the patient needs particular instruction, which he or she does not seek until some suggestion is made."

Dr. Le Grand Kerr has—and so have many other doctors—printed instruction blanks, interlined for additions and modifications to meet the needs of individual patients. On these charts, in addition to general instructions, are printed a number of captions, of which the following are examples:

1. A normal, healthy childhood is the best life insurance any adult can acquire.
2. The certain thing about health is its uncertainty; guard it.
3. Do not let your good intention suffer by inattention.
4. The malnourished child may make the pessimistic adult.
5. "They say" harms more children than it helps.
6. Children do not outgrow disease; they must be helped.
7. Teething is a natural process; it may cause discomfort; never disease.
8. What helps a neighbor's child may harm yours.
9. Diet is often more important than medicine.
10. No two babies are alike; then, why not treat them as individuals.

The Pinellas County (Florida) Medical Society of St. Petersburg, Fla., carried the following advertisement in the daily papers:

"The following physicians are members in good standing of the Pinellas County Medical Society, the Florida State Medical Association, and the American Medical Association": Under this advertisement were signed the names of thirty-six doctors with their office addresses. The object of this advertisement was to counteract the influence and prestige which was being gained by certain advertising doctors, some of whom were as blatant and as unscrupulous as any that can be found in the daily press of the nation.

After seven months of this advertising—"The members of the society feel gratified with the results attained. Not only have they counteracted the prestige which they seemed to be losing, but they fixed the ethic standards of the profession clear and strong in the public mind. At the same time they established themselves individually as being physicians of the first rank, and worthy of the respect and confidence of their fellow-physicians."—Medical Economics.

The Public Services—Examinations of candidates for entrance into the United States Public Health Service will be held at San Francisco, Cal., March 2, 1925.

Candidates must be not less than 23 nor more than 32 years of age, and they must have been graduated in medicine at some reputable medical college, and have had one year's hospital experience or two years' professional practice. They must pass satisfactorily, oral, written and clinical tests before a board of medical officers and undergo a physical examination.

Successful candidates will be recommended for appointment by the President with the advice and consent of the Senate. Requests for information or permission to take this examination should be addressed to the Surgeon-General, United States Public Health Service, Washington, D. C.

Poor Chiropractors—The chiropractors apparently made their initiative law so exclusive that they cannot get themselves in under its provisions. One board of examiners appointed by the Governor under the provisions of the law has been ousted by the Supreme Court. Charges similar to those used in the first instance have been preferred against the second board. In the meantime an injunction was obtained preventing the board from issuing licenses. By some sort of understanding or misunderstanding, the board issued some 400 licenses and now there is other and more litigation. Chiropractors did not bother much about the law governing practice before, and the fact that they cannot qualify under their own law is not interfering with "business," if signs and advertisements mean anything.

When a horseman is examining a horse, he always pulls out the animal's tongue and looks at his teeth. This is for the purpose of ascertaining his age and whether or not his grinders are in good condition. . . . Many years of experience have taught our physicians that if a patient shows the results of considerable good dental work, he will as a rule pay his physician's fees. Moral: Look in your patient's mouth, not only in the interest of his health, but before you determine upon his credit.—Medical Economics.

Tell "Our Story" to the Public—"The question still remains as to how we are to gain the sympathetic understanding and energetic co-operation of the public. "Without this," believes Gordon S. Fahrni, M.D. (The Canadian Medical Association Journal), "we cannot make progress. Business and other forms of lay organizations, as well as the individuals, are waiting to be informed on the big questions of preventive medicine and of the care of the sick. Many of them have brightening mental pictures of the situation, seeing as they do the abuse of public money in the present system of administration of our charities and public health institutions. They are groping about in the dark, wondering where to begin. I consider it is the duty of the medical profession to show the way in this big question, and by so doing gain a more sympathetic understanding from the public."

Mrs. Wallace Reid Foundation—Some of our members are making inquiry about the Mrs. Wallace Reid Foundation of Los Angeles.

A recent circular letter upon the stationery of that organization shows "Dr. Nathan O. Reynolds, A. M., M. D., as medical director and Harry M. Owens, personal business representative." This letter is addressed to a physician and contains the following statements:

"Our treatment for drug addiction is now being successfully administered with little, if any inconvenience to the patient and a *complete elimination of the drug, with restitution of the patient to a very healthy and cheerful condition within two weeks. Physicians* and discharged patients are now endorsing the treatment in highest terms.

"Our plans of operation are semi-philanthropic and in consequence our charges, considering the *wonderful results attained,* are quite reasonable."

Records of the Board of Medical Examiners show:

"Dr. Reynolds is a graduate of Creighton Medical College, April 27, 1912, and the holder of California physician's and surgeon's reciprocity certificate No. C-1149, issued April 8, 1919, based upon Nebraska license issued June 12, 1912, after a regular written examination."

We would like very much to have the names and addresses of physicians who "are now endorsing the treatment in the highest terms."

All physicians would also be highly appreciative of conclusive evidence of the "wonderful results" being secured at this "Foundation."

For the information of inquiring members of the California Medical Association, it may be stated that, so far as we can find out, the "Mrs. Wallace Reid Foundation" has not been approved, accredited, or endorsed by any medical organization.

Should Fees Be a Personal Matter?—"The Louisiana Medical Society has never adopted a schedule of fees such as other medical societies in many sections of the

country have done," says the New Orleans Medical and Surgical Journal.

"Fees for house calls, as a rule, should be in excess of office charges. Night calls more than day visits. Distance to be traveled, length of time spent at the bedside, character of service rendered, and the type of patient treated, and the patient's economic condition should all be included in determining the charge.

"A flexible scale, excepting routine work, will meet all conditions, assuring to the patient the fullest and fairest treatment, and to the doctor a competence commensurate with his time, service and skill. *Medical fees should not be standardized, and popular impression to the contrary should be corrected.*"

Business Methods in Charity—Eastern newspapers are prominently featuring the Charity Services of Doctors, as expressed in money values. Calculated upon a basis of $1 a visit, the services of doctors run into millions of dollars, even for a single group associated with a single hospital. If figured upon the basis of $1 a visit; $1 for laboratory examinations; and $5 for x-ray, and even $10 for operations, the *services for which no compensation is asked or received* for the citizens of California during 1924 would be in excess of $10,000,000. It would exceed $4,000,000 in San Francisco alone.

If we are going to set up our charity work in dollars and cents, why not be generous enough to include the figures for medical service, as is done for every other kind?

How many colds do you have in a year? The average for Americans is four apiece. It takes about three weeks to recover from a cold. So, then, most people are wretched and ineffective a fourth of their time as a result of this common ailment. A stamping out of colds would be more valuable to the world than the discovery of an elixir which would add a decade to life.

More Should Do So—"Personally," says a layman (Medical Economics), "I am through with taking advice that doesn't fit me, even if it comes by radio from high medical authorities. Twice a year now I have myself thoroughly examined and surveyed by my physician, and if there is any trouble indicated, I have it attended to at once. I keep the bridge running away from me; I do not worry about crossing it. The periodic health examination is good sense and good business. I am just as much for it as I am for regular inspection of elevators and of steamboats and factory boilers. Then, if anything is found wrong, I am convinced that an expert ought to hunt the trouble and remove its cause."

Discovery Always an Evolutionary Process—"No discovery in the basic medical sciences, no advancement in the art of healing is to be credited to any single individual," says C. M. Jackson of the National Research Council. "Even the greatest heroes of medicine, those most richly endowed with the precious gift of creative imagination, are indebted to their predecessors for instruction and inspiration, to their contemporaries for criticism, and to their successors for the final adaption and evaluation of their most original products."

"Full service to the patient calls for team work. The captain is the doctor. No team is any more worth while than its constituent members. The nurse, the social worker, the laboratory expert, the specialist, the pharmacist, the physiotherapist, and others may one or all constitute the team which the physician directs."—Medical Economics.

Medical License as Old as Medicine—In India, 600 years B. C., a student, after completing a rather hard course of study, had to petition the king and secure his permission before he could practice medicine.

After 3000 years of "progress" a fad may be substituted for a hard course of study; advertising for a petition to the king and membership in a fighting organization in lieu of permission from the government.

The Michigan State Medical Society at its last annual meeting amended its constitution and by-laws to fix the annual membership dues at $10. This was done to extend its work and increase its usefulness. Thus the Michigan State Medical Society has again recorded itself as an organization that refuses to stand still or even to move slowly in discharging its recognized duties to its members and its state.—A. M. A. Bulletin.

Several other medical societies are expanding their constructive programs and taxing themselves to pay for the increased service.

The Board of Education is operating a "Guidance Clinic" in Minneapolis. They are also operating a hospital as a "School for Tuberculous Children." A few doctors of medicine are on their large staffs largely as "advisors" and "consultants."

Pharmacy Advertising—Good reliable pharmacy supplies are as important to the doctor and his patient as is reliability in surgical instruments or any other equipment or service. CALIFORNIA AND WESTERN MEDICINE takes pleasure in calling attention to our growing list of advertisers of pharmacy supplies and prescription pharmacists whose products and service may be depended upon. These pharmacists are patronizing, and thereby helping to support the publication owned and published by physicians. They are entitled to your consideration. They are, Broemmel's Prescription Pharmacy, Fitzhugh building; Butler's Pharmacy, Flood building; Exclusive Prescription Pharmacies, with five stores in San Francisco and one in Oakland; H. L. Ladd, 343 Powell street; Lengfeld's, 216 Stockton street, and F. J. A. O'Ferrall, The Dispensary, 5199 Geary street.

All of these pharmacies are in the bay district, but we hope to carry, in early issues, the announcement of reliable pharmacies in Los Angeles and other cities of the state for the convenience of our many members there.

California Pollens—Through an error, the advertisement of California pollens, M. L. Austin, 3201 Fifth avenue, Sacramento, was omitted from the January issue of CALIFORNIA AND WESTERN MEDICINE, although it has been running continuously for the last two years. For this we wish to apologize. The production and use of reliable pollens is a business of growing importance, less seasonal in California, of course, than in many other places.

Transportation of the sick is an important and growing movement among many agencies that serve health. Like other services, to be of the best, it must be conducted by those experienced in the work. We are glad to note that the American Ambulance Company of San Francisco announces itself in this class in the advertising pages of CALIFORNIA AND WESTERN MEDICINE every month.

E. R. Squibb & Sons—We are particularly glad to welcome to our advertising pages again the well-known house of E. R. Squibb & Sons. This contract for a page space ought to reassure those physicians who had grown curious about whether this firm had decided to make its appeal in California exclusively to the consumer instead of inviting the endorsement of physicians as had been their previous custom.

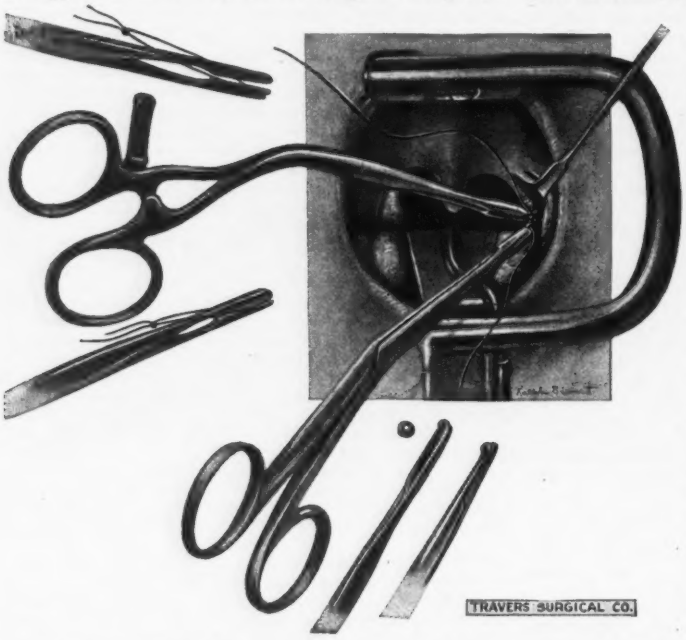
Infant Foods—It is always difficult to know just what infant foods to accept and what to reject in the advertising columns of an ethical medical journal. Many of these products are worth while; many are purely commercial, while others have both advocates and critics. We feel, however, that CALIFORNIA AND WESTERN MEDICINE is making no mistake in accepting, and thereby endorsing, the copy of the Nestle's Food Company and of the Merrell-Soule Company, manufacturers of Klim, which appear for the first time in this issue. In addition, you will find the announcements of our old friends, Dennos Food Company; Horlick's Malted Milk; Knox Gelatine; Mead Johnson & Company; Mellin's Food; and SMA of the Laboratory Products Company.

One Group of Specialists Appeal to Another Group—The Wells Fargo Bank and Union Trust Company, who are advertisers in CALIFORNIA AND WESTERN MEDICINE, have issued to all physicians an attractive and unique pamphlet under the title of "There Aren't Enough Hours in the Day."

Clinical Notes, Suggestions and New Instruments

TONSIL LIGATING INSTRUMENTS

This set of instruments, devised and improved by Doctor C. R. Bricca of San Francisco, consists of two forceps and mouth gag (Davis). The forceps, as illustrated, are an angle-bent haemostat, which carries a looped ligature with a single knot, so that when any vessel is seized the ligature encircling the vessel enables the operator to tie the same, visibly, by aid of the forceps with a ring on the upper blade. One end of the ligature is passed



through the ring, and by pushing the knot over the end of the haemostat and with gentle traction on the other strand the knot is easily completed.

These instruments eliminate the use of all needles and traumatizing haemostats, and also the tying of the pillars together. The instruments being angle-bent, allow the operator an unobstructed view of the surgical field, and the hands of the operator are outside the visual line. Any size blood vessel can be visibly ligated with these instruments, regardless of location.

These instruments are manufactured and distributed by the Travers Surgical Company, San Francisco.

PERFORATIONS OF STOMACH AND DUODENUM DUE TO ULCERS

Comment by Ralph Van Vranken, M. D., Los Angeles, Calif.

There is probably no surgical condition that has been more often discussed or results that have been more often fatal than perforations of the gastro-intestinal tract. Early diagnosis followed by immediate surgery is, without doubt, the most adequate method to lower the mortality.

In all perforations of the gastro-intestinal tract it is of the greatest importance that the site of the perforation be determined prior to surgical interference. Too often an incision is made in the lower abdomen, expecting to find an appendix as the seat of the trouble when in reality the stomach is the focus of the condition. The increased hauling around of the viscera and contamination due to such an error is often most telling on the patient, say nothing of the embarrassment to the occasional individual that operates for an acute appendix, sends patient back to bed, and in the morning, when the autopsy is done, the pathologist finds a perforation of the stomach.

It is with this in mind that I wish to bring out a few cardinal points that help to differentiate this condition from other acute conditions of the abdomen. The following points I have observed from about six or seven perforated cases that I have seen in the last few years.

The patients were usually about middle age. All the cases that I have seen have been men. The patients were thin, emaciated, and in a condition of severe shock. They usually gave a history of previous stomach trouble of possibly years' duration. Soda bicarbonate had previously given relief. The present trouble struck them suddenly like a knife going through them. The cases were all pictures of acute peritonitis and, if seen early, the pain was more noticeable on palpation at the pit of the stomach or over the area of the perforation. The usual case was sweating when seen, or had sweated rather profusely before. Quite frequently there was pain in the right shoulder. One case seen, this was the main complaint of the patient. Hiccough, vomiting, and markedly rapid respiration was noticeable separately or in combination in about one-half of the cases.

The temperature was usually close to normal or slightly subnormal. The pulse was rapid and thready. The blood pressure showed a decrease. It is of significance that the blood picture shows little variance from normal, save there being a slight decrease in R. B. C. and hemoglobin. The urine often showed a trace of albumin and acetone.

These cases were operated on by an incision above the navel, in the midline. The sight of the perforation was readily accessible in all cases, except one which was in the posterior part of the duodenum. The holes were purse-stringed and then lapped over, drains inserted under the liver, another one in the midregion, and a third drain was brought up through a stab wound just above the bladder.

Patients were put to bed in Fowler position and given nothing by mouth for three days except a mouth wash, which was given the patient from the start. Normal saline was given under the skin, about 1000 cc. every eight hours, and drop method by rectum continuously until the third day, when Sippy treatment was started.

Five patients left the hospital alive and one died. This one was operated on about twenty-four hours after rupture, the others from six to eighteen.

As a summary, I might say that patients with perforations of the stomach or duodenum should be operated on as soon as a diagnosis is made. It is very hard to differentiate between perforations of stomach and duodenum. The abdomen should be opened above the umbilicus, so as to avoid undue handling and contamination. Cases of acute peritonitis that give a history of acute onset where pain is or was greatest in the abdomen above the umbilicus, where there is hiccough, pain in the shoulder or rapid respiration, where the temperature is practically normal, and the blood picture shows little variance from normal are usually perforated stomachs or duodenal ulcers and should be treated as such.

1039 East Vernon Avenue.

Medicine being a science of man, for man, and by man, must be learned from man through a study of man to a large though varying degree. The evil that holds modern medical education in its grip is too much theory and not enough practice; too much talk about the bedside and not enough sitting by it.—*Illinois Medical Journal.*

A great physician long ago said that a scientist who could not make any scientific fact clear to any intelligent person did not know his fact or it was not a fact.

TRUTH ABOUT MEDICINES

New and Non-official Remedies

(Abstracts from reports of Council on Pharmacy and Chemistry, A. M. A.)

Note—These do not represent all of the actions of the Council, but they do represent those remedies manufactured by firms who co-operate with CALIFORNIA AND WESTERN MEDICINE in its advertising columns, and thereby with the physicians of California.

Iletin (Insulin—Lilly) U-80—Five cc. ampules containing 80 units of iletin (insulin—Lilly) (New and Non-official Remedies, 1924, p. 152) in each cc. Eli Lilly & Co., Indianapolis.

Ampules Adrenalin Chloride Solution Rx 1, 1:1000, 1 cc.—A solution of adrenalin chloride. Parke, Davis & Co., Detroit.

Ampules Adrenalin Chloride Solution Rx, 1:2,600, 1 cc. — New and Non-official Remedies, 1924, p. 117. Parke, Davis & Co., Detroit.

Ampules Adrenalin Chloride Solution 1:1,000, 1 cc. New and Non-official Remedies, 1924, p. 117. Parke, Davis & Co., Detroit.

Thigenol—Solution Sodium Sulpho-Oleate (Roche)—A solution of the sodium salts of synthetic sulpho-oleic acid containing 2.85 per cent of sulphur. Thigenol has the actions and uses of sulphoichthyolate preparations (New and Non-official Remedies, 1924, p. 350). The Hoffman-LaRoche Chemical Works, New York.

Hypodermic Tablets Strophanthin 1/100 grain (Lilly)—Each tablet contains strophanthin U. S. P. 1/100 grain. Eli Lilly & Co., Indianapolis.

Hypodermic Tablets Strophanthin 1/120 grain — Lilly.—Eli Lilly & Co., Indianapolis.

Ampules Ouabain 0.0003 gm. (1/128 grain)—Lilly—Each ampule contains ouabain crystallized—N. N. R., 0.0005 gm. in 2 cc. of a buffered, sterile normal salt solution. Eli Lilly & Co., Indianapolis.

Antidysenteric Serum — P. D. & Co. — (New and Non-official Remedies, 1924, p. 301.)—An antidysenteric serum, also marketed in packages of one syringe containing 20 cc. Parke, Davis & Co., Detroit.

Insulin (Squibb)—A brand of insulin (New and Non-official Remedies, 1924, p. 149). It is supplied as insulin (Squibb) 10 units (5 cc. vials containing 10 units in each cc.), and insulin (Squibb) 20 units (5 cc. vials containing 20 units in each cc.). E. R. Squibb & Sons, New York. —Journal A. M. A., November 8, 1924, p. 1509.

Pituitary Extract—Lilly (Obstetrical) — A slightly acid aqueous solution containing the water soluble principle or principles of the fresh posterior lobe of the pituitary body of cattle. It is tested for oxytocic action on the isolated uterus of the virgin guinea pig against a standard solution prepared from defatted desiccated posterior lobe powder and adjusted so that its strength is equal to that of a 5 per cent solution of the fresh posterior lobe of the pituitary gland. For a discussion of the actions and uses, see general article, Pituitary Gland, New and Non-official Remedies, 1924, p. 225. Pituitary extract—Lilly (obstetrical) is marketed in ampules containing 0.5 cc. and 1 cc., respectively. Eli Lilly & Co., Indianapolis.

Pituitary Extract—Lilly (Surgical)—A slightly acid aqueous solution containing the water soluble principle or principles of the fresh posterior lobe of the pituitary body of cattle. It is tested for its pressor action on the blood pressure of mammals and for oxytocic action on the isolated uterus of the virgin guinea pig against a standard solution prepared from defatted, desiccated posterior lobe powder and adjusted so that its strength is equivalent to that of a 10 per cent solution of the fresh posterior portion of the pituitary gland. For a discussion of the actions and uses, see general article, Pituitary Gland, New and Non-official Remedies, 1924, p. 225. Pituitary extract—Lilly (surgical) is marketed in ampules containing 1 cc. Eli Lilly and Co., Indianapolis.

Secacornin—Ergotin (Roche)—A solution of the active principles of ergot in a menstruum consisting of distilled water, glycerin and 7.5 per cent of alcohol. One cubic centimenter secacornin corresponds to 4 gm. ergot, U. S. P. The actions and uses of secacornin are the same as those of ergot. It may be given by intramuscular injection. Hoffmann-LaRoche Chemical Works, New York. —Journal A. M. A., November 29, 1924, p. 1769.

Harmonizing Workmen's Compensation Laws—The National Industrial Conference Board, Inc., makes the following suggestions for increasing the efficiency of industrial accident laws:

"At least one member of each state compensation board should be a physician who should also be the medical director of the board.

Each board should have a consulting staff of specialists to advise it on medical problems.

Examining physicians should be appointed by the state board on recommendation of the consulting staff on the basis of their professional qualifications.

Only licensed graduates of recognized medical schools should be permitted to treat compensations cases.

Medical fees should conform to the average charges for like work in the community.

'Medical treatment' should include all necessary medical, surgical, and hospital care and attendance and also such supplies and appliances as may be necessary.

Examination of an injured worker should be made immediately following the injury, and later examinations should be at the expense of the party requesting the same.

The choice of physician should be made by the employer or be made by the employe from a list of local physicians compiled by the employer.

Copies of the findings of examining physicians should be furnished to all interested parties, and reports and testimony of other physicians should not be allowed before the board till medical representatives of the other party have knowledge of the information to be given.

The refusal of medical treatment by the injured worker should release the employer from further responsibility in the matter.

Amputations should be made with regard to the function of the part remaining and not alone with regard to the amount of tissue removed, which latter proceeding might leave a tender appendage, useless for applying an artificial member and would, at the same time, in some states reduce the compensation of the injured employe.

Autopsies should be made at the request of the employer, the beneficiaries, or the state board, and should be paid for by the party requesting them.

Compensation for disease alleged to be due to accident should be granted only on proof of direct causal connection between the accident and the onset of the disease.

Compensation for the aggravation of latent or pre-existing disease should be limited to the degree of disability caused by the aggravation.

The per cent of reduction of vision and its economic valuation should be based on the age and occupation of the employe, and each case should be judged on its merits and not by a predetermined schedule.

Claims that hernia has been caused by employment must be made within twenty-four hours of its alleged occurrence and must be supported by proof of certain specified conditions.

Compensation should be granted for occupational diseases that are peculiar to the employment or are due to some unexpected result thereof. The term 'and sequelae' frequently used in connection with occupational disease schedules, should be eliminated.

Every one of these suggestions may be found in the compensation laws of one or more of the states; but, the conference board points out, their substantial inclusion in all the state laws would obviate much of the confusion and difficulty now experienced in the administration of these laws."

NOTE—Our readers will please note the quotation marks.

Some Phases of Rejuvenation—The role played by the gonads and the chromatin threads and chromosomes of the cell nucleus of sperm and ovum in the determination of sex is reviewed by William T. Belfield, Chicago (Journal A. M. A., April 19, 1924). He states that in the number of chromosomes of the united sperm and ovum we recognize, not the immutable determination of the sex of the new being, but rather a distinct impulse toward the building of one or the other sex; an impulse that must seemingly be transmitted, as is the distinctive chromosomal structure, to every cell in the body; an impulse which early becomes manifest through the instrumentality of the endocrine glands, including the gonads. This recognition of the fertilized egg as the fundamental factor in sex is essential; it elucidates the otherwise puzzling fact that there is no group of sex features exclusively associated with testis or ovary; and other facts—including possibly homosexuality—inexplicable on the prevalent assumption that sex features emanate from gonads. Defective plans are sometimes manifest in structures deviating from the human type that cannot be explained by human embryology, but which are clearly features of earlier animals in the vertebrate phylum—the so-called arrests of phylogenetic development. The demonstrated difference in cell structure between male and female suggests the possibility that every cell in the body may contribute toward maleness or femaleness; as yet, however, only endocrine glands, including gonads, and cranial ganglions have been proved to make and unmake sex characters. Brown's work indicates that the function of the gonads requires integrity of certain ganglions at the base of the brain, which may be compressed through tumor formation of the pituitary; and that atrophy of the testes may be due to pressure on them rather than to pituitary disease. Among the organs which influence structure and function of the testes must be included certain ganglions at the base of the brain. On the traditional conception that sex emanates from testis or ovary is based the idea that the two sex complexes are essentially antagonistic and immutable. The biologic conception of sex is, on the contrary, not that it comprises two antagonistic entities, but rather that it is a single entity presenting various—and variable—degrees of femininity. There are known many instances in which the female—bird, quadruped or human—has matured normally, and later has assumed in marked degree the features and functions of the male; there is no instance known in which a mature male vertebrate has through intrinsic forces exhibited the corresponding change toward the female type; once a male, always a male; once a female, later a near-male, seems the natural course. Transmutation of females toward maleness, apparently anomalous, is such only in degree; for in all warm-blooded species the heavy burden of reproduction imposed on the female is transitory; and cessation of ovulation is often accompanied by some exchange of feminine for masculine features. Despite the wealth of pertinent observations, clinical and experimental, the influence of gonads on sex character is not yet exactly defined.

Homotransplantation of the human testis should, on biologic data, be more promising than that of the ovary; for these data indicate that the somatic tissues, inherited through the fertilized egg from the entire vertebrate phylum, are in harmony with the ancient maleness, but not with the new femaleness of the placental animals—that they are homologous with the testis, but heterologous toward the ovary. And since, for the structure and maintenance of sex characters, somatic tissues—the endocrines at least—are as essential as are the gonads, the male castrated before maturity may develop partial maleness—thanks to his somatic tissues—while the spayed young female lapses—thanks to those tissues—from femaleness toward maleness. Hence it seems possible, a priori, that a testis transplanted into an otherwise normal young man deprived of the testes might reinforce the maleness of the host's somatic tissues, even though the ovarian transplant into the female fails to do so. Belfield asserts that Steinach's method of rejuvenation merits little attention; for it is founded on error and refuted by experience. Steinach's theory of rejuvenation—for men at least—falls to the ground. The experimental work of careful investigators on rejuvenation by testis implantation seems to have established these results on animals: Testis transplantation succeeds often in young, rarely in old, animals; success meaning merely the maintenance of vitality for a period of months. Though the transplant never produces sperms in its new host, it may function to the extent of preserving the masculinity of a castrated young male for a limited time, or of causing in a spayed young female hypertrophy of the clitoris and distinctly masculine behavior. The life of the transplant is much shorter than that of the native testis; within a few months its elements are replaced by connective tissue, and its physiologic effect on its host ceases. Stimulation of erection sometimes follows testis transplantation in old men, appearing within a few hours and ceasing within a few days. This is apparently the effect of preformed substances contained in the transplant and absorbed therefrom by the host's tissues. Similar effects have followed the injection of milk. A lasting recovery of lost erectile power in old men through testis transplantation is yet to be demonstrated. The future of testis therapy seems to depend on the isolation of the activating substance produced in the testis corresponding to thyroxin or insulin. Until this shall be accomplished, the injection of an emulsion of testis tissue seems the most promising form, though such a mixture of unknown proteins must be a tentative remedy. It seems probable that gonad therapy begun as an irrational attempt at an impossible "rejuvenation," may emerge from the disrepute of its infancy, and develop into a valuable means for relieving ailments that are not now associated with gonad deficiency; for it is demonstrated that the gonad does not originate sex; that it is less essential to the maintenance of sex than is the thyroid or the suprarenal; and that it is indeed one of a chain of interacting endocrine glands, efficiency in every link of which is essential to normal function, sexual or somatic.

"A Rapid Method for the Determination of Gastric Acidity by Means of Test Papers."—W. Denis, Ph. D., and D. N. Silverman, M. D. (American Journal of the Medical Sciences, Jan., 1925, conclude a study of this subject with the statement:

"It is suggested that the customary titrations of gastric contents with Topfer's solution be replaced, at least at the bedside or in the busy clinic by the determination of the hydrogen-ion concentration by means of test papers for which the only equipment needed is a small vial of these papers which may be carried in the pocket."

Specialists have come in for much criticism on the part of the public and even on the part of the general medical profession, as faddists. Yet it must be admitted that specialization has contributed enormously to the advancement of medicine as a whole. It is important, of course, for the prestige of our calling that specialists shall not lose their sense of proportion, and shall base their particular work on as broad a foundation as possible.—DAVID RIESMAN, *A. M. A. Bulletin.*

"The Physical Basis of Unrest—With civilization have come opportunities for the frequent escape from physical labor of those either clever or stupid enough to evade it. Civilization, in fact, expects the clever to dodge it, while the weaklings among the lower orders necessarily escape yet receive considerable paternal care on the part of the society."—*Medical Times, Jan., 1925.*

Properly restricted newspaper publicity of medical meetings, in which personalities are kept in the background, helps to educate the public, and if and when newspaper editors once realize the importance of having medical news carefully edited by a medical co-editor, much of the disturbing misinformation in which our papers now abound, will be avoided.—*A. M. A. Bulletin.*

MEDICAL STRAWS

By THE EDITOR

Experience is fallacious and judgment difficult

Maternity Mortality Increasing—"More women died in childbirth during 1923 than during 1922," says the United States Census Bureau. Later figures are not available. These are discouraging.

J. J. Sippy, M. D., in discussing what a nurse may and may not do, says (Pacific Coast Journal of Nursing) that a doctor "will leave standing orders for hypodermic administration of morphine and strychnia to the student nurse in the hospital and criticize the better-trained public health nurse for administration of toxin-antitoxin, far less dangerous. It causes one to wonder at our inconsistencies."

"DOING things for people is harmful misdoing unless it increases their independence, energy and initiative."—Henry Ford.

"Today, the doctor takes the helpful point of view that nervous patients are not office nuisances, but are men and women in trouble: suffering, hoping, thwarted, groping, and crippled," says George K. Pratt (Hygeia). "And because he realizes that a special kind of treatment is needed he refers them to his colleague, the psychiatrist, just as he refers operative cases to the surgeon."

Over 90 per cent of the 100 per cent of people who need a physician's advice are walking about and attempting their duties. If they were adequately and efficiently cared for, our hospitals would be half empty.

THE successful physician is a counselor of health as well as a purveyor of pills.—Henry Shaw (Nation's Health).

DISCIPLINE is the mainspring of action and operation, the first price of successful achievement in any field or forum.—Russell.

Apply it upon yourself in the interests of your patients as thoroughly as you do in your golf.

"I SHOULD like to emphasize the fact that even the ordinary practitioner in the smallest village, far from hospital, laboratory or library, can, if he will, make some contribution to medical progress."—C. M. Jackson (National Research Council).

A "sectarian," as applied to medicine is one who, in his practice follows or claims to follow a dogma, tenet or principle based on the authority of its promulgator to the exclusion of demonstration and experience.—House of Delegates, A. M. A.

Quite a satisfying definition.

A physician is one who has acquired a contemporary education in the fundamental and special sciences comprehended in the term "medicine" used in its unrestricted sense, and who has received the degree of Doctor of Medicine from a medical school of recognized standing.—House of Delegates, A. M. A.

Compare that excellent definition with the legal definition of most states and we get a close-up of how government interferes with the progress of health.

PHYSICAL examinations of the well are all right, but they should be performed by the family doctor. This work should not be done second-handed through the medium of some health institute.—Journal of Indiana Medical Association.

There seems to be a prevalent idea that almost anyone can make a diagnosis of a patient who is walking about.

THE average meal consumed today is the outgrowth of the efforts of *cooks who have catered to taste rather than to reason.*—N. P. Norman, M. D. (New Jersey Medical Journal).

The Unkindest Cut of All—We don't expect very much any more in this old vale of tears and laughter, but perhaps the hardest thing to forgive the professional reformers is pasteurized cider.—Ohio State Journal.

THE modern business man of the best type has a code of business ethics that might well be adopted by those physicians who are in the medical profession "for what they can get out of it" and not for the amount of service they can render the public.—Edward J. G. Beardsley (New Jersey Medical Journal).

NATURE has not yet adopted union laws and union hours, nor union standardization, and state medicine will have to travel farther and faster than it has been doing to get nature into this set standard.—Illinois Medical Journal.

Professional "Toters" Will Be a New Profession—The lower house of Congress has passed a bill restricting the use of the United States mails for the transportation of firearms that can be concealed upon the person.

One Baby Per Month for Each Doctor—It is announced that 87,000 babies were born in California during 1924. If all of the births were apportioned to educated physicians only, each would have officiated at one birth a month.

SOMEONE has defined an expert as a man who lives 100 miles away and charges $100 a day for his services.

The quoted "fee schedule" is too low for the "expert" who must pay his publicity agent. And many newspaper editors are growing more discriminating between "news" and "advertising."

"THE heart of a man has not capacity enough to feel as a mother feels at the grave of her son," says a proverb.

Nor has he the consolation of such close communion with Him who said "Suffer little children to —"

"QUACKERY and the love of being quacked are in human nature as weeds are in our fields."—John Brown.

Weeds—and quackery—grow best on the golden grain fields, the sun-kissed fruit plains, and the breeze-bathed shores of the mighty Pacific. Love of being quacked grows in inverse ratio to intelligence.

MEMBERSHIP in a county medical society is a badge by which the general public determines whether the physician is interested in his colleagues, interested in keeping abreast of modern advances in medicine, and interested in an unselfish protection of community health (Ohio Medical Journal).

Doctors, that is worth reading again, pondering and measuring ourselves by.

THAT *commercialized prostitution* is the principal means of disseminating syphilis and gonorrhea is emphasized by many popular "health educators."

Is it?